16651/SAB/PJB Attorney ID# 6224469

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS -
EASTERN DIVISION**

KRISHNA NARSIMHAN Plaintiff, vs. LOWE'S HOME CENTERS, LLC, Defendant.	))))))))	Case No.: 1:19-cv-01255

PLAINTIFF'S MOTION IN LIMINE # 15

TO BAR THE TESTIMONY OF JOSHUA PRAGER, M.D. OPINION THAT DR. FARBMAN WOULD HAVE DIAGNOSED COMPLEX REGIONAL PAIN SYMDROME

NOW COMES Plaintiff, KRISHNA NARSIMHAN, by and through his attorneys, ANESI, OZMON, RODIN, NOVAK & KOHEN, LTD., prior to the selection of the jury in this cause, moves this Honorable Court to enter an Order *in Limine* barring and prohibiting Defendant, LOWE'S HOME CENTERS, LLC, or its counsel, agents, employees and/or any witness called by the Defendant, or questions by defense counsel from making statements, offering evidence, testimony , remarks, arguments or from conveying directly or indirectly to the panel by any means, including the fact that this motions have been presented and ruled upon, for the subject matter identified in the title and body of this motion, and in support states as follows:

INTRODUCTION

Plaintiff seeks an order from the Court barring any testimony of Defendant's medical witness, Joshua Prager, MD, Plaintiff's treating doctor would have recognized and appreciated Complex Regional Pain Syndrome signs and symptoms in 2016

through 2018 if such were present. Defendant's witness uses this belief as a basis for his opinion that Plaintiff is not suffering from CRPS. Plaintiff argues this testimony is irrelevant, unfairly prejudicial and unreliable in that it is speculative and does not meet the *Daubert* standard.

RELEVANT FACTS

Defendant's Medical Witness, Dr. Joshua Prager, speculates as to what another doctor may have done. Specifically, Dr. Prager states that it was his belief Dr. Farbman was a "competent neurologist" and therefore, if CRPS signs and symptoms were present, he would have appreciated them:

(Exhibit A. Deposition of Dr. Joshua Farbman, page 120, line through page 121, line 21, taken on 06/21/21)

Q. Okay. And in this case, Mr. Narsimhan saw Dr. Farbman and Dr. Saeed, and I think in your opinion, the Budapest criteria was not properly documented, correct?

A. Nobody ever -- I mean, Dr. Farbman's account from what I gleaned from reading his notes and the way he does things -- it appears he may have retired. I don't know. I got that impression from the chart. But I got the impression he was a competent **neurologist that were CRPS present he would have picked it up**. (emphasis added)

Q. What gave you that impression?

A. Because a competent neurologist should be able to do that.

Q. You think any competent neurologist in the world should be able to do that?

A. Well, should and does are two different things, but if it's a competent neurologist, "should" fits.

Q. How do you -- what makes you think that Dr. Farbman is such a competent neurologist that he should be able to perform a Budapest criteria examination and document it properly?

A. Well, that's a whole different thing. That's different than what you asked me, sir. What you asked me is would he be competent to be able to make a diagnosis, and documenting it is another thing. But based on the way his notes are written -- and believe me, I see the broad spectrum of notes. And based on the quality of his notes, it's my opinion that he's a competent neurologist. Now, I'm not there at

his own institution, but he's not at a shabby institution either. That in a good institution somebody who keeps good notes, who doesn't copy his notes from visit to visit verbatim is a competent neurologist.

Q. Is there any other reason other than doesn't copy his notes from day to day that indicates that Dr. Farbman is a competent neurologist capable of understanding and performing and documenting the Budapest criteria, anything else?

(objection omitted)

A. And, Ms. Hay, thank you, because I was going to use nonlegal words to say he was twisting what I was saying. And the bottom line is, I'm not saying that he was competent to document the diagnostic criteria for CRPS, but he's competent to be able to make a diagnosis even if he doesn't document it properly or at the minimum -- and this is really important – at the minimum raise in his differential diagnosis, which any competent neurologist would do, would raise the possibility of CRPS if it was present, and he did not do that.

ARGUMENT

Relevant evidence is evidence that has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." *Fed.R.Evid. 401* Relevant evidence is excludable under Federal Rule of Evidence 403, on the basis that its probative value is outweighed by the danger that it will cause unfair prejudice, confuse the issues, mislead the jury, cause undue delay, waste time, or be needlessly cumulative. *Fed. R. Evid. 403.* Dr. Prager is offering evidence of another doctor's state of mind that is irrelevant and prejudicial since he has no basis for such an opinion.

The admissibility of expert witness testimony is governed by Rule 702 of the Federal Rules of Evidence and the body of case law that has developed from the Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). Under Rule 702, expert testimony is admissible if "scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." Fed. R. Evid. 702. Rule

702 also "requires that (1) the testimony must be based upon sufficient facts or data; (2) it must be the product of reliable principles and methods; and (3) the witness must have applied the principles and methods reliably to the facts of the case." *Happel v. Walmart Stores, Inc.*, 602 F.3d 820, 824 (7th Cir. 2010)(citing Fed. R. Evid. 702). This rule "applies to all expert testimony, not just testimony based on science." *Durkin v. Equifax Check Servs., Inc.*, 406 F.3d 410, 420 n.10 (7th Cir. 2005).

Rule 702 requires that the district court act as a "'gatekeeper' who determines whether proffered expert testimony is reliable and relevant before accepting a witness as an expert." *Autotech Tech. Ltd. P'ship v. Automationdirect.com*, 471 F.3d 745, 749 (7th Cir. 2006). In exercising its gatekeeper function, a district court must examine (among other things): (1) the expert's qualifications; (2) the expert's methodologies; and (3) the relevance of the expert's proposed testimony. *Adams v. Ameritech Servs.*, 231 F.3d 414, 423 (7th Cir. 2000).

Courts are expected to reject any subjective belief or speculation by an expert. *Ammons v. Amamark Unif. Servs., Inc.* 368 F.3d 809, 816 (7th Cir. 2004).

The proponent of the expert bears the burden of demonstrating that the expert's testimony would satisfy Rule 702 and *Daubert. Lewis v. CITGO Petroleum Corp.*, 561 F.3d 698, 705 (7th Cir. 2009). Although required to perform its role as a gatekeeper, a district court's "[d]eterminations on admissibility should not supplant the adversarial process; shaky expert testimony may be admissible, assailable by its opponents through cross examination." *Gayton v. McCoy*, 593 F.3d 610, 616 (7th Cir. 2010). Courts are expected to reject any subjective belief or speculation by an expert. *Ammons v. Amamark Unif. Servs., Inc.* 368 F.3d 809, 816 (7th Cir. 2004).

The deposition testimony offered by Dr. Prager is nothing more that pure speculation as to another doctor's thoughts and impressions during an examination and how that doctor would respond. Further, the testimony assumes he knows the background, training, experience, and knowledge of not just Dr. Farbman, but every neurologist, and that it is the same and therefore, would have acted in the manner he (Dr. Prager) would have under similar circumstances.

Dr. Prager's testimony is speculation as to the knowledge and familiarity that Dr. Farbman "should have had" as a "competent neurologist". It is not based in any scientific, technical or specialized knowledge. He has no basis to give an opinion as to how Dr. Farbman would observe and appreciate during an examination, nor does he have any idea Dr. Farbman's background, training, experience and knowledge of CRPS such as to identify, diagnose or even raise its possibility. He has no basis to make any statement that Dr. Prager, let alone any other neurologist, would have done at anyone particular time without having the ability to read the mind of such doctor.

The speculative testimony by Dr. Prager has no basis in fact and assumes that Dr. Prager would be able to "read the mind" of Dr. Farbman years after the subject medical treatment Dr. Farbman provided to the Plaintiff. The only witness who would be in a position to give any testimony in this regard would be Dr. Farbman himself.

Dr. Prager admits that he is not familiar with Dr. Farbman either personally or by reputation. (*Ex. A, Pg. 34: 3-5*) This testimony is irrelevant, unfairly prejudicial and unreliable. There is no scientific, technical or specialized knowledge that he is using to arrive at this opinion. Nor is this an opinion that would be necessary or even helpful for a jury in order to decide the issue of this case.

CONCLUSION

WHEREFORE, Plaintiff respectfully requests this Court enter an order barring and prohibiting Defendant, LOWE'S HOME CENTERS, LLC, or its counsel, agents, employees and/or any witness called by the Defendant, or questions by defense counsel from making statements, offering evidence, testimony, remarks, arguments or from conveying directly or indirectly to the panel by any means, including any testimony by Dr. Prager as to:

- As to Dr. Farbman's background, training, experience and knowledge, including, but not limited to the examination, identification and/or diagnosis of Complex Regional Pain Syndrome;
- As to what Dr. Farbman should have been able to observe and appreciate as a "competent neurologist" during the examination of the Plaintiff:
- As to what Dr. Farbman was considering regarding Plaintiff's examination, and based on this, how Dr. Farbman would have recorded signs or symptoms of CRPS;
- That, Plaintiff was not experiencing any signs or symptoms of CRPS because of what Dr. Prager believes that Dr. Farbman "should have" been able to do.

Respectfully submitted:

/s/Steven A. Berman

Attorneys for Plaintiff

Steven A. Berman sberman@anesilaw.com
Patrick J. Blum pblum@anesilaw.com
ANESI, OZMON, RODIN, NOVAK & KOHEN, LTD.
161 N. Clark St. / 21st Floor
Chicago, IL 60601
Telephone: 312/372-3822
Fax: 312/372-3833

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KRISHNA NARSIMHAN,)
)
Plaintiff,)
)
-vs-) Case No. 1:19-cv-01255
)
LOWE'S HOME CENTERS, LLC,)
)
Defendant.)
)
_____)

The deposition of JOSHUA P. PRAGER, M.D., called for examination pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Judith T. Lepore, Certified Shorthand Reporter for the State of Illinois, License No. 084-004040, via videoconference, at the hour of 3:03 p.m.

ALL APPEARANCES VIA VIDEOCONFERENCE:

ANESI, OZMON, RODIN, NOVAK & KOHEN, LTD.
BY: STEVE A. BERMAN, ESQ.
161 North Clark Street
21st Floor
Chicago, Illinois 60601
312.372.3822
sberman@anesilaw.com
Representing the Plaintiff;

HEPLER BROOM LLC
BY: LINDA HAY, ESQ.
30 North LaSalle Street
Suite 2900
Chicago, Illinois 60602
312.230.9100
linda.hay@heplerbroom.com
Representing the Defendant.

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EXHIBITS

THE REPORTER: On the record. This deposition is being taken by means of Zoom video teleconference. The attorneys participating in this deposition acknowledge that I am not physically present in the deposition, and the oath will be administered remotely.

The parties and their counsel consent to this arrangement and waive any objections to this manner of reporting.

Will all counsel present please state your name and indicate your agreement on the record.

MR. BERMAN: Steve Berman. I agree.

MS. HAY: Linda Hay for the defendant. Agreed.

(Witness duly sworn.)

MR. BERMAN: Doctor, will you please state and spell your full name.

THE WITNESS: Joshua P. Prager, M.D., M.S., D.A.B.P.M.

MR. BERMAN: Is it P-r-a-g-e-r your last name?

THE WITNESS: Correct.

MR. BERMAN: Thank you.

For the record this is the deposition of

EXHIBIT
A

Dr. Joshua Prager taken pursuant to notice and taken pursuant to the applicable Federal Rules of Civil Procedure.

JOSHUA P. PRAGER, M.D.,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BERMAN:

Q. Dr. Prager, I'm assuming you've given depositions before, right?

A. I have. I'm just trying to clean up -- because I'm having a little trouble hearing you. So I'm trying to clean up some background noise here, and I think I already did.

Okay, I have. And if you're going to ask me about the admonitions, I'm happy to dispense with all admonitions or no admonitions, but I prefer not to have some --

Q. I'm happy to dispense with all of them. Except for one thing I would to say everybody -- for the record at least I say is, if there's ever a question I ask you that's not clear in any way or not understandably phrased, don't answer and ask me to

rephrase it. If you answer the question, I will assume you understood the question the way it is was phrased, okay?

A. Fair.

Q. Let's go through some brief background information.

What is your -- what's your date of birth?

A. [redacted]/49.

Q. What's your residence address?

A. [redacted], Santa Monica, California.

Q. And what is your profession?

A. I am a licensed medical doctor.

Q. What is the name of your practice or where you practice?

A. Well, it's Joshua Prager, M.D. is one; California Pain Medicine Centers is two; and Center for the Rehabilitation of Pain Syndromes (CRPS) is 3.

Q. Do you have a particular office or address of an office, or do you practice out of multiple locations?

A. I practice out of one office.

Q. What's the address of your office you practice out of?

A. 2001 Santa Monica Boulevard, Suite 1280 West, Santa Monica, California.

Q. And you're here today because you've been disclosed as a retained medical expert on behalf of the defendant Lowe's in this Narsimhan versus Lowe's litigation, correct?

A. That is correct.

Q. And you performed work as a medicolegal expert on other cases as well, not just this one, correct?

A. Correct.

Q. In this case you reviewed certain records; you performed an examination of Mr. Narsimhan; and you've come to certain opinions and conclusions; is that fair?

A. That is correct.

Q. And as sort of a beginning stage or beginning point, I kind of want to make sure about what you've reviewed, start there. But before I even do that, I'm going to -- I have literally two exhibits in this deposition, Doctor. I'll show you what's been marked as Exhibit A, what we're marking as Exhibit A. And all Exhibit A is is the notice of deposition that has the rider to it, and I'll just show you.

(Whereupon, Exhibit A was marked for identification.)

BY MR. BERMAN:

Q. So can you see my screen, Doctor?

A. I can.

Q. So Exhibit A is just a notice of virtual deposition with a rider it says for June 21st, 3 o'clock Central Time, and then the rider is attached to it. Have you seen this document?

A. I have not.

Q. Have you produced to the defense any documents in conjunction with this rider?

A. No, it doesn't look like I have, but I have some of them at my disposal.

Q. Well, let's just talk about that for a moment.

Per the rider for Exhibit No. 1 is your CV. I have a copy of your CV that's marked in Deposition Exhibit No. 2, which is going to be the disclosure of yourself which contains your reports and your CV and your testimony list. So we can dispense with No. 1.

No. 2 asks for any and all publications and presentations authored or prepared by you that form the basis for or support any of your opinions in this

case. Do you have those with you today?
A. I'm just trying to think if they -- just because I gave a presentation I wouldn't be using it to support, and the same for publications. So although I've published -- well, I don't know that the publications and even -- well, the publications that I have written about CRPS do not relate to this case, per se. And the presentations that I give, I don't actually have access to. So, I mean, the basis for my opinion is literature that I have read, which is not requested here explicitly, and also experience of caring for these kind of patients for better than 25 years.
Q. Okay. So at least it looks like the rider item No. 2, there would be no document that would comply with that because there's no particular publications or presentations that you've prepared or authored that relate specifically to this Narsimhan case?
A. Specifically, correct.
Q. Let's move on to three. All deposition transcripts, literature, articles, textbooks, other documents, or things you reviewed in conjunction with this case, and do you have those in front of you,

those items?
A. Yes.
Q. We can go over what those items are. I'm not going to ask you to list them right now. I'll do that in a moment, so I will dispense with that one.
No. 4 asks for notes, preliminary impressions, opinions, reports, letters, or other documents generated by you in conjunction with this case. We know you prepared at least two reports; one relating to the medical examination itself, and one that was attached to the 26(a) disclosure. What I'm wondering is, do you have any notes or handwritten notes or preliminary impressions or thoughts written down other than those reports?
A. I do not.
Q. Do you have any kind of -- going back to No. 3 where it talks about deposition transcripts or documents reviewed by you, do you have medical records that have handwritten notes on them or Post-it notes that include some of your thoughts while you were reviewing those?
A. I reviewed everything electronically, and I didn't create any electronic notes.
Q. So for No. 4 there would be nothing to

respond to, right?
A. Correct.
Q. No. 5 says, "Copies and citations of any articles, texts, literature, rules, regulations, or other materials upon which you rely to support your opinions in this case." Are there any articles or texts or literature that you rely on to support your opinions in this case?
A. There would be I would say essentially one article that has particular relevance, which is Harden's article on the diagnosis -- the diagnostic criteria for complex regional pain syndrome; otherwise known as the Budapest criteria.
Q. Dr. Harden's article, when was that from?
A. I believe around '03, but I don't know for sure.
Q. Are there any other literature, articles, texts that you think would be supportive of your opinions in this particular case?
A. Well, you know, actually, I haven't explored with anyone or written about anyone about treatment for CRPS, but I could rely on either treatment guidelines or a particular article regarding treatment algorithm for CRPS. I hadn't thought about that until

you're asking me now. But I certainly know what are in both of those, and either one could suffice to discuss treatment.
Q. Do you have a name or a citation of a particular article in mind that you're referring to right now?
A. There was one originally by Boas, B-o-a-s, and then a modification or just an update on that was written by Stanton-Hicks regarding treatment for CRPS.
Q. What year or years were those articles?
A. They are relatively old. I think Boas was around '98, and Stanton-Hicks was around 2000.
Q. Do you have the citations for any of those articles that you just --
A. I don't. It's just that I've read them, and I know them.
Q. And obviously the reason I'm asking you this question in the deposition today is because I put this in the rider asking for this information that would be relevant for me to potentially question you about during today's deposition. So you haven't produced those to defense counsel who retained you in this case, have you?
A. If we want to take just a brief pause, I

could probably find them on the internet really quickly and send them to defense counsel who could then send them to you. I don't think it would take more than five minutes. Because I haven't done that, I would deduct the time it takes me to do that from time you're paying for and also suspend the time of the deposition if necessary.

Q. I appreciate that, and we can do that when we're off the record. So I appreciate that.

Just to follow up on this one for No. 5 here, are there any articles, texts, or literature say that were written or produced in the last five years that you think are particularly relevant to CRPS or your opinions in this case?

A. No.

Q. Have you written any articles regarding CRPS in the last five years?

A. I think only in relation to the use of ketamine.

Q. The next one is No. 6. It talks about correspondence between yourself and defense attorneys or anyone on defendant's behalf. Was there any correspondence between yourself and any attorneys who retained you in this case?

A. Nothing besides letters of transmittal.

Q. So there are letters of transmittal?

A. Right.

Q. And you would be able to produce those to me as well?

A. I think so. I mean, I don't think if -- if you have my file, you will see what has been transmitted to me. So it will just say we sent you this, and you'll have this. So there's nothing other than that.

Q. The only reason, Doctor, I'm asking you is I don't have your whole file in front of me. I did the rider asking for this information, which I wasn't given any information. I thought you would produce that before today's deposition, but it wasn't. So I'm asking you about it as we're sitting here. So that's the reason.

MS. HAY: Steve, I know that the doctor has an electronic file that he has available, and I note on your rider, you know, the request is for him to produce the materials at the time of or prior to the start of this deposition. So he does have an electronic file in front of him that should contain everything, and we're happy to get a copy of that.

But he has that there and available.

MR. BERMAN: That's what I'm asking for. I didn't get it at the time of or the start of the deposition. So now we're in the middle of the deposition. We're actually inside the deposition, and I'm asking about those details because I haven't been given that before the deposition.

THE WITNESS: I can have somebody create -- while I'm doing it so it doesn't take from our time to upload everything that we have, or at least a list of it, which probably would be more efficient because everything on the list you have. So if you want me to, I'll ask my assistant to just send that list to you.

BY MR. BERMAN:

Q. You know what, in all honesty, I'm not concerned really about you duplicating depositions that you haven't notated or highlighted because I have that stuff or medical records. But if there's handwritten notes or highlights on there, I'd like to see that. If there's letters, if there is, for example, correspondence, I'd like to see that. Invoices, I'd like to see those. Just your entire file relative to this cause of action, I'd like to see

that.

A. Let's see. I lost the screen you were sharing.

Q. I'm not sharing it anymore. I'm not sharing the screen because I think the only answer to this question is, you're going to produce your entire file including all the stuff we just talked about in the rider and send it over to defense counsel.

A. With the exception of my income taxes, which I think is an invasion of privacy, and I will not send them.

Q. I'm not going to push that issue. That's a standard request that's done for everybody in Illinois, and for right now at the moment, I'm not going to push it because I don't know either side is going to be pushing that issue.

A. Thank you.

Q. You're welcome. That's all I'm asking for as to Exhibit 1 -- I'm sorry -- Exhibit A, my mistake. For purposes of today's deposition, we'll make Exhibit B the disclosure, so make this really easy. And I'll show you what I'm going to mark.

(Whereupon, Exhibit B was marked for identification.)

BY MR. BERMAN:

Q. So if you can see my screen, Exhibit B is the document in which you were disclosed as an expert witness in the case, and that's three pages. And attached there are Exhibits 1, 2, and 3, so B-1, B-2, and B-3. So B-1 is your IME report, B-2 is your CV, and then B-3 is your expert report in this case, which is three pages.

A. Okay.

Q. And then B-4 is your testimony list.

A. Okay.

Q. I'll just ask you -- I'm not going to go through your CV, Doctor. I've looked at it. It's extensive. I get it. My only question to you, Doctor, is, the one that was attached here as Exhibit B-2 for your deposition today, is that current and up to date or does that need to be made up to date with additional information?

A. It's not completely up to date, but nothing that would be added if I updated it would be particularly -- would be germane to this case.

Q. Okay, I understand that.

So let's start with what I want to talk to you about, which is essentially what information do you have in this case, what records or information did you review relative to this case. And to do that I'm going to go to again Deposition Exhibit B, which is the 26(a)(2) disclosure of yourself. Have you seen this document before by the way?

A. No.

Q. You can see that it's three pages. The reason I'm using this is because it seems to list everything that you reviewed. So I'm going to ask you to take a brief look at it and tell me if the list is accurate. So starting at facts or data considered here --

A. Right.

Q. -- in forming opinions. I can make it bigger. And go through at least one and two and tell me if you reviewed all that information.

A. I have.

Q. Okay, good.

And then 3, 4, 5, and 6, did you review all that information?

A. Yes.

Q. Is there anything that you reviewed that's not listed in this --

A. I believe I did receive something subsequently. Let me just go into my file and tell you -- what's the last date that you have of when I received things? There is 4/23/21.

Q. I don't think it tells us. Oh, it does. It says 4/23/21.

A. So on 5/20 I received Wheaton Chiropractic, two files. On 5/4/21 I received four -- no, three deposition transcripts, which I thought I saw there. Well, Jodi Rankin is one of them. For whatever reason I have these in No. 6, but it wasn't listed with a date and time. New ones that I'm showing you are -- there were two records in one PDF. One of them was from a psychologist, and for whatever reason it's not booting on my computer. Hold on a second.

I'm not sure what the problem is. I could try to do it off this computer. I have two computers here. This one doesn't want to let me go to -- here, let me try one other thing.

Q. Sometimes technology doesn't help.

A. Okay, let's try from scratch here.

Okay, now it came up. So there's a Dr. Patricia Merriman. I have two notes from her.

And I have a note from Dr. Patel that was cosigned by Dr. -- okay, here's Dr. Patel's note. By Dr. Buvanendran. Those are the only things I received. And in that same receipt of documents were a number of pictures taken by the plaintiff.

Q. So the only thing -- I've gone through this list in your Deposition Exhibit B of the documents you reviewed, facts or data considered by Dr. Prager in forming his opinions, and it's records, it's information, it's also depositions that you reviewed. Correct so far?

A. Yes.

Q. It also includes a video, the video of the -- I assume of the incident.

A. Correct.

Q. Did you view that?

A. I did.

Q. Okay, good.

It seems to indicate under No. 4 here that you were sent on 4/2/21 your own Rule 35 IME report. Is that accurate?

A. I assume so. I mean, I already had it. It's called "Records Received." Let's see on 5/2 what I have.

Q. That's the question that I was wondering. Maybe that was a mistake because it seems like it's your own report.

A. It is my own report, and it was not sent to me on that date.

Q. Fair enough.

From looking at this, you reviewed multiple depositions. I wrote it down. You reviewed the deposition transcript of Krishna Narsimhan, the plaintiff himself, right?

A. Right.

Q. You reviewed the deposition transcript of Dr. Saeed; is that right?

A. Correct.

Q. You reviewed the deposition transcript of Dr. Joshi?

A. Correct.

Q. You reviewed the deposition transcript of plaintiff's wife, Kerri; is that right?

A. That one I discussed -- no, I don't believe I've reviewed that one.

Q. Fair enough. That's why I'm going over them. You never know.

Did you review the --

A. Hold on. I just want to make sure. I know I didn't review that in preparation for today. Let me just make sure I never reviewed it.

Q. It's under No. 6 here deposition transcripts. It says, Kerri Krishna.

A. I don't have files that are organized that way.

It doesn't look like I have that one.

Q. And it is strange the way it's listed on this Exhibit B. It's listed in No. 6, Kerri Krishna, not Kerri Narsimhan. But the bottom line is you don't believe you ever reviewed the deposition transcript of plaintiff's wife, Kerri?

A. Hold on one second. One more time.

I don't believe so, no. I don't recall.

Q. And next one's listed as Jodi Rankin. Did you review the deposition transcript of Jodi Rankin?

A. Yes.

Q. Was there anything in that deposition of Jodi Rankin that you felt was relevant to your medical opinions in this case?

A. I reviewed that a while back, and I'm just trying to conjure up in my memory. But I think she did comment at that time about what his complaints

were which I had concern about, if I'm remembering it right.

Q. Well, Jodi Rankin, she was just a store employee. She was an employee of Lowe's. She wasn't a medical provider.

A. She is not the one who took a phone call?

Q. She was.

A. Right, okay. Apparently, Mr. Narsimhan explained -- at least from what I remember of the deposition, he was complaining about burning pain in his leg to her.

Q. Is that relevant to you, to your opinions?

A. Yes.

Q. How?

A. If we have an allegation of CRPS based on the injury that occurred, we wouldn't expect that by a piece of metal hitting the lower part -- or essentially around the ankle from the front would cause burning in the back. If that were to become a CRPS symptom, it would take weeks to get to that point, and it doesn't make anatomical sense, if I'm remembering that that was the source of that complaint.

Q. So just I'm understanding you for a moment

before we move on, the complaint -- if the complaint to Jodi Rankin on the day of the occurrence, you know, shortly after the occurrence was that he was having burning pain in the area where he was struck by the bar, would that affect your opinions?

A. Well, I don't remember it being that way. But hypothetically, if he had burning pain exactly where it hit, that might not be extraordinary, but if it were proximal to it, which there certainly are -- if that's the place I read it, somewhere else in short temporal proximity to the event, you wouldn't get burning pain proximal to a strike on the ankle if it were CRPS, or to tell you the truth in almost any other situation, right after being hit on the ankle because there's no way to explain why that would occur.

Q. I'm just wondering is it the location of the symptom or the type of symptom itself that's of issue?

A. Well, I think, Mr. Berman, what you're asking me is if it was -- he had burning precisely where the thing hit him, it wouldn't mean that much to me from a negative standpoint. If it's anywhere else -- now, for distal it's something else, and distal would mean going toward the toes. But that's not where he's

complaining about. He's complaining about it going up his leg, and up his leg is something that takes -- I mean, to put it in lay terms, time to percolate.

Q. Right, okay.

A. It wouldn't happen in short temporal proximity.

Q. All right. So let's go on. I was asking about depositions. I'm sorry. I took a little detour there. Sorry about that.

So you did read Jodi Rankin's deposition. Did you read the deposition of Physical Therapist Lisa Schwartz?

A. Yes.

Q. Did you review the deposition transcript of Dr. Motiwala?

A. I think you're pronouncing it wrong, but I did read that deposition.

Q. It could be pronounced different, but that's the way it's spelled so I'm going to go with it.

A. No, you put an N in there that I don't think is there.

Q. Matiwala?

A. It's Matiwala, not Mantiwala.

Q. Matiwala.

A. Yeah.

Q. That's what I thought I said, but I'm sorry if I messed it up.

A. No apology is necessary to me.

Q. I'll call her later.

All right. So the question I have is, did you review the deposition of Physical Therapist Brian Fischer?

A. I don't recall doing that.

Q. Did you review the deposition transcript of Dr. Buvanendran?

A. I did.

Q. You did, okay. That's not listed in this disclosure.

A. Are you sure?

Q. Pretty sure.

A. There it is. The records -- oh, that's Narsimhan right under there. Well, I apologize. I did review that.

Q. That's why I check.

A. Good.

Q. I missed it, too, Doctor. I'm just checking.

A. It would have been in the same batch where I got his CV, so if it's not listed there somebody made

an error.

Q. Okay. The bottom line is, you did review it?

A. Correct.

Q. Okay, wonderful.

MS. HAY: Just to be clear, Steve, I think you might have mentioned it, and I'm not sure if I see it. I was trying to pull up the document, but I'm having a little bit of difficulty. And it's hard to read the entire document you have here. But he did review Dr. Joshi's testimony, too.

MR. BERMAN: I think that was on there.

THE WITNESS: I think it was on there, too.

MS. HAY: I see it there. There it is under No. 5.

BY MR. BERMAN:

Q. At least I didn't miss that one.

Okay. Are there any other records or deposition transcripts that are not included on that disclosure that you think that you reviewed that we can update or record today?

A. Not that I know of.

Q. Terrific.

The records you reviewed, the medical records you reviewed, are those the type of records that a

doctor such as yourself could reasonably rely on in formulating opinions like this?

A. That's an excellent question, and it's not a simple answer because those kind of records are what I would attempt to rely upon pending the way things are documented -- actually, probably just the best way to put it is, depending on how things are documented, but also depending on how things were particularly done in order to allow me to fully depend upon them.

Q. Let's see if I understand your answer, and I think I do.

A. You may want to mute.

Q. What's that?

A. Somebody may want to mute because there's a siren going.

Q. That's actually coming out of my window.

A. You can't mute, okay.

Q. No.

A. Don't worry about it. If it was one of the other -- well, Judy's on mute herself.

Q. I'm going to suppress background noise.

A. It's gone now.

Q. Is that better?

A. It's much better.

Q. Good. If there's a problem with the audio, just let me know. I'll try to fix it.

So, again, I'm just going to follow up and come back to your last answer. The records you reviewed in this case you said you would normally -- are the type of records you would rely on except it kind of depends on how the examination findings are documented in the records, right?

A. Correct.

Q. So in other words, when you're reviewing a case such as this -- and you've done this before, I know -- you've come across I assume some doctors that don't document their findings as well as others; is that fair?

A. That's definitely fair.

Q. In this particular case, you reviewed the records, and did you have some concerns about how Dr. Farbman's records were documented?

A. Not particularly.

Q. In this case did you have any concern about how any of the examinations -- strike that -- how any of the doctors documented their findings or examinations relative to my client Mr. Narsimhan?

A. Yeah, I'm just trying to remember. The first

doctor in I believe 2018, the first doctor to suggest a diagnose of complex regional pain syndrome was Saeed, and I'm trying to remember if she adequately documented the criteria in order to entertain such a diagnosis.

Are you still there?

Q. I thought you were looking up something to answer the question regarding Dr. Saeed's initial diagnose of CRPS. I was just waiting for you honestly.

A. Sorry. I was waiting for you. I was just saying that based on my recollection I don't remember seeing in her notes sufficient documentation to establish a diagnosis of CRPS.

Q. You mentioned you received records from a Wheaton Chiropractic Clinic, I believe?

A. That's correct.

Q. Was there any records of information contained in those records that was of relevance to your opinions in this case?

A. Yes.

Q. What?

A. That throughout that treatment that was -- I'm just tying to remember how long. It was, I

remember, about three months of treatment. If I remember right, in 2016 from September to December, he was being treated for pain. And if I remember right, there were about 20 of those visits during that three-month interval, and not once was there a complaint of leg pain.

Q. What was he being treated for during that time frame?

A. His arms and hands.

Q. At Wheaton Chiropractic?

A. If I remember right, yeah. Why don't we go there and see.

Sorry it's taking so long. Maybe if I did a search under Wheaton, it would come up quicker. There it is, okay. So here we have -- that one is not useful.

Well, here, just if we look at -- I'm looking for the date of this form that Mr. Narsimhan filled out himself on it looks like 5/20/16. It's a little hard to read how he filled out the form. But nonetheless, at some point in 2016 -- oh, it's 9. He just makes a funny 9. He fills out a form on 9/20/16 where it says, "pain and numbness or cramps," and he puts in his hands but he doesn't put in his feet or

his legs either. It's only his hands.

Q. Okay.

A. And he indicates that he has moderate frequency and moderate intensity. And then the examination report -- okay. Well, here's a patient progress report dated 10/11 where the only complaints that he fills out or that are filled out relate to the arms and shoulders, and there's nothing on the legs. And what I can tell you is, I have 68 pages of notes. During the course of reviewing those 68 pages of notes -- and here is a form. I believe this was filled out by the patient himself. He's only complaining of pain in the wrist, hands, and neck of recurring -- yeah. And here is a note, a typed note, thank God, left wrist, left forearm, so his complaints are completely limited to his upper extremities. And what I can tell you -- we can go through all these notes, but I think it's wasting your time and money to do it because my best recollection of all these notes -- I mean, here, we'll go to one of the last notes, neck, arms, wrist, diagnoses, cervical, cervical, forearm, okay, and that's December. So now we've just spent three months, and we're only up to page 22. And what I can tell you is, I've been

through all these notes and not that recently, but it was important to me when I went through them that there was nothing related to his lower extremities, although he's very vocal about the pain and numbness in his upper extremities.

Q. Okay, I understand what you're saying. From your experience, Doctor, do chiropractors typically treat neuropathic pain?

A. That's what apparently they were treating him for here in the upper extremities, pain. I mean, I think your question is a good question. I'm not sure why he's referred there in the first place.

Q. I'm asking you, in your experience, in your opinion, do chiropractors treat neuropathic pain?

A. They can. It's not what they usually treat.

Q. Do chiropractors treat CRPS?

A. Unfortunately I've seen the case where they have, but I don't think it's a good idea.

Q. I hear you.

All right, let's move on. I'm going to ask you about some of the doctors that names you're familiar with in this case, and the question is going to be for each one: Are you familiar with one of those doctors or medical professionals personally or

by representation, okay?

A. Okay.

Q. Let's start with Dr. Farbman, are you familiar with him personally or by reputation?

A. No.

Q. What about Dr. Saeed?

A. No.

Q. What about Dr. Motiwala?

A. No.

Q. What about Physical Therapist Brian Fischer?

A. No.

Q. A Physical Therapist Lisa Schwartz?

A. No.

Q. What about Dr. Buvanendran?

A. It's interesting because I think his name may have sounded slightly familiar to me. And I looked him up, and so I have some idea who he is. But very interestingly we were both on a conference call last week. But he did not say so much as one word, and he didn't put his camera on. I believe that was him. I can't say that for sure, but I believe it was. But his camera wasn't on, and he didn't say a word. And that's the only contact I remember having with him.

Q. To be fair, with regard to Dr. Buvanendran,

you don't know him personally?

A. Correct.

Q. And what, if anything, can you tell me you know about Dr. Buvanendran from a professional reputation standpoint?

A. I think he has an interest in CRPS.

Q. Other than that, anything else?

A. He's on the faculty of Northwestern, if I remember right. He's a medical faculty member.

Q. Anything else?

A. I believe he's esteemed in his field.

Q. Okay, fair enough.

I know that you, Doctor, are one of -- I don't know if I'm phrasing this right, but one of the few doctors who performs a dorsal root ganglion stimulation procedure; is that accurate?

A. Yes. At the time whatever was written said that that was the case. More people are doing it now.

Q. Dr. Buvanendran is one of those doctors who performs that type of dorsal root ganglion stimulation procedure, correct?

A. I believe so.

Q. I'm going to ask you about -- before we get into the meat of your testimony, I'm going to ask you

a little about your overall review of -- your time reviewing this particular case. Can you tell me how much time it took you to review all these records we were just listing earlier?

A. Well, I have to say to you, Mr. Berman, that unfortunately it's never been tabulated. And I do most of that work from home, and I didn't bring those individuals tabulations. And what I can promise is, well before trial you will have a summation of all that, but it hasn't been done. The only thing I've invoiced the defense for is my hotel and air.

Q. Okay, all right. So let me switch gears and do it this way. Maybe this will be a shorthand version for you. I'm going back to Exhibit B. In Roman numeral six, "a statement of the compensation to be paid," and it lists your compensation schedule. Is this accurately listed?

A. Well, the independent medical examination is not because it was on out-of-town one, and that's my fee for in in-office medical exam. So the other one is a much higher fee.

Q. What was the fee you charged defense counsel for your independent medical examination of Mr. Narsimhan?

A. Well, if you're going to be legalistic, I haven't charged them anything else.
Q. What fee will you be charging?
A. Yeah, it was two days of my time at $8,000 a day.
Q. So $16,000 total for the IME?
A. Correct. Well, the IME and travel to be fair.
Q. All inclusive?
A. Correct.
Q. Does the rate for performing an IME include the report itself as well, or is that extra?
A. No, that's all inclusive.
Q. Your deposition time, is this accurate, $1,500 per hour?
A. Correct.
Q. Does that start when the deposition starts?
A. Yes.
Q. So in terms of say, for example, time preparing, time reviewing records and getting ready for today's deposition, is that charged at the 960 per hour rate?
A. Correct.
Q. Then I think you said you haven't prepared

and invoice, but you will. And that will include specific listings of the amount of time you spent reviewing records, consulting with the attorney, preparing for the deposition, all at that $960 per hour rate, right?
A. In excruciating detail.
Q. And I know you said that you performed -- strike that.
I know you've been retained as an expert witness not just in Illinois or California but throughout the country; is that right?
A. That's correct.
Q. And is that because you're a recognized expert in the field of CRPS?
A. Well, it's not only CRPS. I have expertise in spinal cord stimulation, precision spinal diagnostics and therapeutics, intrathecal pumps, yeah. But, you know, Mr. Berman, you're predominantly right, probably 80 percent of that retention is related to CRPS, but my expertise in spinal cord stimulation is comparable to my expertise in CRPS.
Q. I understand. And also you're a practicing medical doctor in the field of pain management at this time as well, right?

A. That's correct.
Q. So you see patients, right?
A. 80 percent of the time.
Q. Okay. In terms of -- so just take out the times when you're a treating medical doctor, and the times -- I'm just going talk to you about the times you're retained as a medical expert witness in litigation. For the times you're retained as a medical expert in litigation, what percentage of the times are you retained by a representative of the injured party versus the times you're retained by someone who the injured party has a claim against?
A. Okay. I'm going to give you a complicated answer that I'm sure you'll be happy. I am retained initially by the plaintiff probably about two-thirds of the time. When it comes time for a designation, I am retained -- or the retention is maintained about 60 percent by the defense and 40 percent by the plaintiff. If you want an explanation, I can give you why that is.
Q. I'm not sure even what that means. Can you explain that?
A. Yeah.
Q. The designation.

A. By the end, let's say trial, it would be 60 percent defense. But there's an attrition, for lack of a better word, of many of the plaintiffs' cases before we get to that point.
Q. Got it. I didn't realize.
In terms of your work as a medicolegal expert, how much money do you earn or generate per year say over the last four or five years?
A. I'm prepared to discuss that in percentage, and in percentage up until last year, I was estimating somewhere around 16 percent because 20 percent of my time is not caring for patients. And of that 20 percent, about 80 percent of it is medicolegal. So up until last year it was about 16 percent. But during COVID my medical practice decreased, so the percentage of medicolegal percentage-wise went up over 20 percent. Do you follow that?
Q. Not really. When you answer in percentages, it doesn't really answer my question because it's too vague, so I'm just going to ask you to answer the question that I asked. If you want me to repeat it, we can repeat it.
A. Well, I think I understand the question. And we don't break it out here the way revenue comes in,

so I don't really have a full answer. My estimate is about up until last year under 20 percent, and with COVID over 20 percent.

Q. All right. If I'm understanding what your answer is, you're saying that your revenue that relates to medicolegal work specifically, not treating patients, is 20 percent of your income; is that what you're saying?

A. I'm saying that, yeah, up until last year it was. This year, now that my practice is busy again, the percent of medicolegal is going down again. But last year -- I think you understood what I said -- that because my practice income went down and the medicolegal practice stayed about the same, I had a higher percentage of medicolegal than I had in any other prior year because I just -- my medical practice income was substantially reduced.

Q. So then if we're going back to 2019 and you're saying that 20 percent of your practice's income relates to your medicolegal work only, what's the total practice income so I can figure out the 20 percent of it?

A. Well, that we would have to have a discovery referee tell you that that's necessary for me to tell.

total practice's revenue so that we could figure out the 20 percent of that as just your federal, you can answer that, but you wouldn't because you think it's an invasion of privacy; is that fair?

A. Correct.

MS. HAY: Note my objection based upon the doctor's answer.

BY MR. BERMAN:

Q. Would that be true for 2018 as well, Dr. Prager?

A. It would be true for all years.

Q. For this particular case, can you tell me the name of the law firm that initially retained you?

A. Yes, it was Lewis Brisbois.

Q. My question for you, Doctor, have you ever been retained by any attorneys from the firm Lewis Brisbois other than in this case?

A. Not in Chicago.

Q. What about in any other city?

A. I've probably done two or three cases for Lewis Brisbois' Los Angeles office.

Q. And have those other two cases that you've been retained by defense counsel Lewis Brisbois, have those been retentions on behalf of a defendant in a

Q. So you won't -- you could answer that question, but you won't?

MS. HAY: I think the doctor -- just a second, Doctor.

I think the doctor already testified that he couldn't estimate those specific numbers because his practice isn't set out that way, so I think he's already answered that.

MR. BERMAN: I don't think he answered that specific question. I think he changed the question. Can we have the doctor answer the question specifically?

MS. HAY: Sure. I think he already asked and answered it. But, Doctor, you can answer it again.

THE WITNESS: What I said is that I don't know that that is information that -- it appears to me that that's an invasion of privacy, and that -- I've been asked the same question probably 20 times, and in all 20 times including federal court when I've declined to answer that question, the judge has vindicated my decision to do that.

BY MR. BERMAN:

Q. All I'm asking you right now is you understand that the question is, in 2019 what was your

case?

A. I cannot swear to that, but I believe that that would be true.

Q. What about defense counsel that's currently handling the defense of this case Hepler Broom, have you ever worked with that law firm before?

A. I don't believe so. We could ask Ms. Hay if I -- and then I would testify to whatever she tells me, but I don't know of any. I guess only the --

Q. You shouldn't say that, by the way.

A. I think it's only the second case I've done in Chicago.

Q. All right. Turning your attention to Mr. Narsimhan and his case specifically.

You understand from your review of the records that Mr. Narsimhan was involved in an incident on June 25th, 2016, in which he was at Lowe's and a metal bar fell onto his right lower extremity just above the ankle, right?

A. Correct.

Q. And you saw the video of that; you know that that incident occurred, correct?

A. Correct.

Q. As far as you reviewed the records of this

entire case and your entire knowledge of Mr. Narsimhan and his life, is it fair to say that you have no knowledge of Mr. Narsimhan complaining of any prior right lower extremity pain or symptoms prior to the incident of June 25th, 2016?

A. That's correct.

Q. You agree that the impact between the metal bar and Mr. Narsimhan's right lower extremity was a traumatic impact?

A. That's an interesting question, because to a layperson the word "traumatic" has big meaning. To a physician, it just means something out of the ordinary essentially. And so we have minor trauma, moderate trauma, severe trauma, and just so that I'm clear on what I'm expressing, I would consider this a minor trauma.

Q. What was the weight of the metal bar that landed on Mr. Narsimhan?

A. I don't remember.

Q. What was the speed at which it contacted Mr. Narsimhan's right lower extremity?

A. I haven't read a biomedical or bioengineering analysis to know the answer to that.

Q. If you don't know the weight of the bar or

the speed at which it contacted Mr. Narsimhan's right lower extremity, why do you call it a minor or minimal impact?

A. Because I saw the video.

Q. Any other reason?

A. That's a good reason.

Q. Any other reason?

A. No.

Q. You saw in the medical records that since the incident -- sorry. You saw in the medical records and deposition testimony that since the incident of the impact between the metal bar and Mr. Narsimhan's right lower extremity, he has been consistently complaining of pain and symptoms of discomfort in that right lower extremity, correct?

A. No.

Q. That is not correct?

A. It's correct that it's not correct.

Q. When was Mr. Narsimhan's pain or discomfort healed such that he wasn't complaining of any pain or discomfort in that right lower extremity?

A. During the interval at least from 9/16 to 12/16, but I actually don't see complaints really until -- well, there were some complaints, but I

didn't see anybody entertaining a diagnosis of CRPS for over two years following that incident despite the fact that there were intermittent complaints of pain. But then there were sustained periods, or at least one sustained period where there wasn't, but I believe there were other periods where there were no complaints.

Q. Did you review Dr. Farbman's records, correct?

A. I have.

Q. And he treated Mr. Narsimhan in July 2016, August 2016, October 2016, February 2016, March 2017, May 2017, April -- I'm sorry -- August 2017, February 2018, April 2018, May 2018, and June 2018. You saw those records, correct?

A. I did.

Q. And throughout those records were locations of complaints of pain in the right lower extremity. Do you acknowledge that?

A. Well, throughout might be a stretch, but there were intermittent at least complaints of pain in the right lower extremity.

Q. In what record did you ever see in Mr. Narsimhan's case that says his right lower

extremity pain had gone away?

A. Well, I don't think there was one where it said it went away, but I think there were ones where there were not descriptors of it. And I would have to look that up to find out specifically when that was.

Q. When you said -- I think what you said to me was that in the chiropractic records there was no description of right lower extremity pain, correct?

A. I did say that, yes.

Q. Is it your opinion then that during the time that Mr. Narsimhan was seeing a chiropractor for his neck and upper extremities that he was therefore not experiencing pain in his lower extremity?

A. Well, I mean, you're the lawyer with res ips, or I think that's the term, that if you see it -- well, if it's not documented, then it's not there.

Q. That's not what res ipsa is, Doctor.

A. No, I know. I realize it. That's why I took it back.

Okay. So here I'm just looking here for the date of this evaluation.

Q. Doctor, I know we're pausing here. I'm waiting for you. Are you still --

A. That's correct. I was looking to see if in

Dr. Farbman's notes, I could find -- I mean, he was talking about pain there. He wasn't entertaining a diagnosis of CRPS. He was talking about -- well, he was mentioning the diabetes, if I remember right. He was mentioning peripheral neuropathy with numbness, which is not a sign of CRPS. And contemporaneously and previously he was being seen by Dr., I think his name was Ignatius at Northwestern from 2012, 2015. Then in 2016 just before this incident, he began to be seen by the doctor that you pronounced the name wrong Matiwala. And Dr. Matiwala was constantly discussing the need to better maintain glucose control, and Dr. Matiwala was -- who's I believe a general practitioner, an internist, not a neurologist and not an endocrinologists as misstated by one of your experts. But Dr. Matiwala was just working really hard to get good insulin control or good -- he said the insulin dosage had not changed in many years. He wasn't monitoring his glucose. He was gaining weight. He wasn't watching his diet. So there was a lot of things contemporaneously going on that went on beyond the period where this incident occurred.

Q. Doctor, I think you're getting pretty far from my actually question, so let me see if I can

narrow it down. What I'm wondering is -- I know you reviewed records from before and after the incident of 6/25/16. My question for you is, in the records reviewed after 6/25/16, was there any doctor or medical practitioner who noted that the right lower extremity was healed or that the pain had gone away?

A. Well, I think another way of putting it was were there consistent complaints in the records of those doctors that there was pain. Because the way those charts are set up, there aren't problem lists where then you say problem terminated, so whatever they were focusing on that day, whether it be arms and hands, were what they were discussing. And if they weren't discussing the leg at that time, they weren't discussing the leg. It doesn't mean one way or another whether it went away or didn't went away. It just meant that it wasn't enough of an issue that it would be in the record.

Q. Sorry, Doctor. I'm going to ask you to answer the question the way it's phrased, if you can please.

Can we have it read back, Judy?

(Whereupon, the record was read as follows:

"Q. Doctor, I think you're getting pretty far from my actually question, so let me see if I can narrow it down. What I'm wondering is -- I know you reviewed records from before and after the incident of 6/25/16. My question for you is, in the records reviewed after 6/25/16, was there any doctor or medical practitioner who noted that the right lower extremity was healed or that the pain had gone away?)

THE WITNESS: Okay. I mean, the construct of the question makes it hard to answer. And so with that introduction, what I will say is, no one made it go away -- but I want you to include this in my answer -- no one said it went away but there were times where nobody described the problem.

BY MR. BERMAN:

Q. And you read Mr. Narsimhan's deposition in which he indicated in his deposition that from the time of the incident of June 2016 up until the time at least his deposition was given he had consistent pain

in his right lower extremity, correct?

A. Correct.

Q. Mr. Narsimhan himself has indicated that the pain -- (audio interruption) -- any period of time when the right lower extremity pain had gone away or healed subsequent to the incident, correct?

MS. HAY: Excuse me. Steve, could you just repeat that question? You were cutting out just a little bit.

BY MR. BERMAN:

Q. Upon reviewing Mr. Narsimhan's deposition testimony, you would agree that at least Mr. Narsimhan has indicated that he has had consistent pain in his right lower extremity only since the incident of June 2016, correct?

A. He has said that, yes.

Q. And there is no medical documentation to prove otherwise, correct?

A. Well, I actually just provided you documentation otherwise. If we look at Wheaton Chiropractic, there's a three-month period where he is being actively treated for pain, tingling and numbness, and at no point is the leg ever brought up.

Q. All right. So the fact it's not brought up,

I think you said already that that's not an indication he was not complaining of pain in his leg; it's just that it wasn't being treated at the chiropractic clinic?

A. No, he filled out a form himself, okay, in his handwriting with his signature where he did not -- where they asked him. I mean, it was a diagram and a table where his diagram of his pain only included his hands, and the table where you could check off leg or foot was not checked off. So that was not only the facility or the chiropractor himself, but it was also Mr. Narsimhan not filling in leg pain.

Q. Okay. So if Mr. Narsimhan didn't fill in leg pain because he wasn't at the chiropractor to treat his leg pain, he was being treated for the leg pain by the neurologist, would that affect your opinions in any way?

A. No.

Q. From your entire review of this case, are you aware of any other traumatic incident or event that injured Mr. Narsimhan's right lower extremity other than the incident at Lowe's in June of 2016?

A. That's a very good question, and I am not.

Q. From your review the record, would you at

least agree that the impact between the metal bar and Mr. Narsimhan's right lower extremity at Lowe's caused Mr. Narsimhan pain?

A. I agree with that.

Q. You have an opinion as to the diagnosis of the pain that the incident of the metal bar hitting Mr. Narsimhan in right lower extremity, what it was?

A. I think you got garbled again there. I don't know if anybody else heard it, but I couldn't hear it.

Q. Okay. Let me ask you some general questions first. As a recognized expert in CRPS, would you agree that in most patients CRPS is a chronic condition that can be permanent?

A. It is a chronic condition that can be permanent that can also go into remission.

Q. In what percentage of cases that you're aware of are symptoms of CRPS permanent, and in what percentage of cases do those go into remission completely?

A. In my practice more than 50 percent of the patients go into complete remission.

Q. When you say --

A. It doesn't mean they don't come out of complete remission. But they go into complete

remission, and we follow the ISP treatment guidelines in how we get there.

Q. Are you talking about -- you said greater than 50 percent of your patients go into remission at some point. Is that 51 percent, 60 percent? How would you further characterize it?

A. It's the majority. And I can tell you that my largest referral source for CRPS and our comprehensive interdisciplinary functional rehabilitation program is the workers' compensation system of the state of California because we get such a high percentage of patients back to work. And what I can tell you is in the occupational health literature, people who have been out of work for greater than a year only have an 18 percent chance of going back to work ever, and that we get more than 50 percent of our patients go back to work. And the savings they have in terms of not having to pay future wages are substantial.

Q. That's fine. You didn't answer my actual question, so I'll rephrase it.

A. I answered.

Q. My question is, you say that your clinic gets greater than 50 percent of patients into remission at

some point, and I'm wondering what that percentage is. What does that mean?

A. I don't have an exact number, but it's more than half.

Q. So there's some percentage less than half of patients that never go into remission of CRPS patients?

A. Well, if you want -- I can tell you that the vast majority, like probably over 90 percent get substantial remission even though they don't get complete remission.

Q. Would you agree that a patient has a better -- a CRPS patient has a better chance of achieving remission of symptoms if the systems are recognized early and effective treatment is initiated early?

A. Yes.

Q. In your opinion, when is the best -- from an early standpoint, when is the best time to recognize the CRPS and begin treatment of it?

A. Three months.

Q. Would you also know that patients who are in their teens or 20s have a better chance of achieving remission of CRPS symptoms than other patients?

A. Achieving 100 percent remission, yes.
Q. In your practice do you use Gabapentin as treatment for resolving CRPS pain?
A. Well, not -- resolving is probably not an appropriate term. It is one of the medications that we use in the treatment of CRPS, as well as other neuropathic pain conditions including diabetic peripheral neuropathy.
Q. So you're saying that Gabapentin is used to treat CRPS, as well as other types of neuropathy such as diabetic neuropathy pain, correct?
A. Right. And in fact Gabapentin is FDA approved for treating at least two neuropathic pain syndromes of which CRPS is not one of them, and nonetheless, we use it.
Q. That was my next question. As a recognized expert in CRPS, in your clinic you use Gabapentin as a treatment -- one of the treatments for CRPS pain, right?
A. Right. It's my number two treatment pharmacologically.
Q. In your experience, though, using this particular drug Gabapentin, how effect is Gabapentin in terms of resolving CRPS pain 100 percent?

A. Well, I mean, we keep coming back to resolving the CRPS pain. I don't think Gabapentin resolves any kind of pain. Gabapentin treats pain successfully, and the limiting factor on Gabapentin is not any kind of toxicity. It's just side effects that are not permanent, and they're not dangerous. But they exist, and that is the limiting factor in using Gabapentin.
Q. I'm not asking you about ketamine yet because I might ask you about that in a minute. But let's stick with Gabapentin for just a moment, Doctor, if you could. In your practice or just in general, can you tell me how effective Gabapentin is in bringing CRPS symptoms into remission like we were talking about, remission?
A. I would say zero bringing it into remission.
Q. So is it accurate to say that Gabapentin is used to help minimize the symptoms of CRPS pain?
A. Yes, and also to be a tool to allow other treatments to do what you were talking about to help get people in remission. Gabapentin by itself will not get you into remission, but it may sufficiently alleviate the pain to allow you to participate in a functional rehabilitation program that can then get

you into remission.
Q. You said Gabapentin is also used for diabetic neuropathies. In your opinion is Gabapentin more effective treating diabetic neuropathy?
A. I think it's equally effective. It's just what I was saying before, Mr. Berman, that it's approved for two neuropathic pain conditions by the FDA. It doesn't mean it doesn't work in other situations. And in terms of comparable amount of pain, I would say it's equally effective in diabetic -- it's very hard to measure pain, but by the way the patient describes the pain to you, if they were describing it with an etiology of what we call DPNP, diabetic peripheral neuropathy pain, or CRPS pain, the same degree of pain would be treated comparably.
Q. I'm going to ask you about CRPS symptoms and signs, and you know those are two different things, right?
A. I sure do. Most don't. Very good.
Q. I'm going to ask you this question, and if you don't like the way it's phrased, just let me know. I'll break it up. But I want to just ask you generally, in your experience can CRPS symptoms and

signs wax and wane from day to day or week to week?
A. Yes.
Q. Can CRPS symptoms and signs wax and wane even throughout the day?
A. Yes.
Q. In your experience can CRPS patients have some good days and some bad days?
A. Yes.
Q. In your experience can CRPS patients have some good days where they have less symptoms and signs than they have on their bad days?
MS. HAY: I'm sorry, Steve. Could you repeat that question?
THE WITNESS: That one got garbled again.
BY MR. BERMAN:
Q. Can CRPS patients have some good days in which they have less symptoms and signs of the CRPS than they have on their bad days?
A. I think that's kind of asked and answered, but the answer is still yes.
Q. I'm still on some of these general questions. This dorsal root ganglion stimulation issue, DRG, that's a surgical procedure; is that right?
A. Correct.

Q. That's an invasive procedure, right?
A. Correct.
Q. Are there certain potential surgical complications that go along with that DRG procedure?
A. Something you didn't ask -- at the beginning you said you're one of the few physicians in the country that perform it. I stopped performing it and do an alternative procedure because of exactly what you're saying.
Q. So what are the potential surgical complications of the DRG procedure that caused you to stop performing?
A. Well, there are a few things. One is not -- two of them are not officially complications as defined. But I've had a hardware failure in multiple -- multiple kinds of hardware failure including a year later having the lead pull out of the pulse generator so it needed surgical revision. I've had multiple leads fracture. And you could call those complications, or you could just call them equipment malfunctions. But regardless of what they are, they require surgical revision, another surgery. But the third one is that in placing the dorsal root ganglion lead there is a risk of hurting a nerve, and that's

probably the principal reason that I stopped doing it.
Q. But also as a surgeon, would you consider that the potential for infection is a potential surgical complication of DRG?
A. It depends. Yeah, officially when I have to read and when I go over the risks and benefits of any surgery, I have to tell patients that there is a risk of infection, but we have an extreme -- I also in my practice, unlike cases that I review sometimes in medical malpractice, we have an extremely low, below 1 percent infection rate requiring explantation.
Q. Doctor, in your experience, with your knowledge of this procedure, the DRG procedure, do you know what the usual and customary and reasonable cost of such a procedure is?
MS. HAY: Just object to form and foundation.
THE WITNESS: Yes.
BY MR. BERMAN:
Q. What is it?
MS. HAY: Same objection, but you can answer, Doctor.
THE WITNESS: Okay. Well, we have to -- there are a minimum of three kinds of charges for performing the procedure. One is called the facility

fee; the other one is either called a technical fee or professional fee; and the third one is the anesthesia fee. And for a trial the professional fee can be anywhere between $1,000 and $9,800 as far as what I've seen. And just so you know, Mr. Berman, I actually do reviews for insurance companies, so I have a pretty good idea of this. I also see lien fees that are multiples of these numbers that I quoted you, but these I don't feel are legitimate fees.
BY MR. BERMAN:
Q. That's what I asked you in your opinion what is a reasonable fee, not a --
A. Okay. Professional between 1,000 and 9,800. For the lead placement, facility, anywhere between 5 and $20,000. For the placement and anesthesia, anywhere between 500 and $1,000.
Q. Is that for the trial of the DRG or permanent implantation?
A. I just gave you numbers for the trial.
Q. What about for the permanent implantation after the trial is completed?
MS. HAY: Just note my continuing form and foundation objections, but you can answer, Doctor.
THE WITNESS: Professional fees, anywhere

between probably 3,500 up to 15,000. Facility fees within reason, anywhere between 28 and 40,000. Anesthesia fees anywhere between 750 and $1,500.
BY MR. BERMAN:
Q. And, Doctor, because there was a foundation objection by Ms. Hay, I want to just make sure you and I were clear. I mean, you were explaining this before. You are aware of this procedure; you are aware of the cost of the procedure in your practice; and also you review these costs for insurance companies so you're aware what the usual and customary and reasonable costs are. Is that fair?
A. Just as you were distinguishing between signs and symptoms, I will distinguish between costs and charges. I think the word you wanted to use was charges rather than costs. Because somebody charges an amount, it doesn't mean they get it. And what they get paid is the cost, but what they charge is what they charge.
Q. In your experience, you can review the charges and make a determination of whether that's what's within the realm of reasonable charges or not, right?
MS. HAY: Same ongoing objections.

THE WITNESS: Right.
BY MR. BERMAN:
Q. And what you were explaining to us earlier were what you consider reasonable charges for such a DRG procedure, correct?
A. Correct.
MS. HAY: Please note all my continuing objections to all of those questions with regard to costs and charges.
BY MR. BERMAN:
Q. Also, I know that you are a recognized expert in ketamine and use of ketamine to treat individuals with CRPS; is that right?
A. Correct.
Q. And you still continue to use that type of treatment, the ketamine treatment to help reduce symptoms or put CRPS symptoms into remission; is that accurate?
A. Not only symptoms, but signs.
Q. Fair enough. So both?
A. Both.
Q. Let me ask you about that for just a moment. Ketamine treatment, are there some potential side effects or potential risks of that type of treatment

for CRPS symptoms and signs?
A. Again, I think it depends on who is administering it because I'm certainly -- we spent about 10 years looking at all possible side effects to see how they could all be mitigated, and I think we have a special sauce so that they all can be mitigated. In terms of actual risks, there is a risk of hepatic injury or liver injury that if you're careful on how you do it; in other words, periodically monitor liver function, if you discontinue it before it becomes a real big problem, it resolves on its own. And, in fact, in our practice, we've noted a few patients that started to have changes in their liver function discontinued, and within a few weeks their liver function was back to normal. That's why I said it depends on whose hands it is, because unfortunately there are, for lack of a better word, cowboys out there that don't read the literature and don't really care for pain patients but only want to administer ketamine infusions for their own personal reasons who don't really do it as a true physician should and wind up with complications. But in the people that I know around the country who are administering ketamine, they're administering it carefully and not having

complications.
Q. In terms of the ketamine treatment that you're familiar with, because you're an expert in it, is this an infusion that's only a one-time infusion; is it multiple times? How long does it take, in other words, and how many treatments does the ketamine take to get the desired effect of reduction or remission of symptoms?
A. Okay. That's a very complicated answer. And this is one where I do give lectures, and the lectures take up a whole hour. Now, all of that whole hour aren't exactly on the question you asked, but it's a more complicated answer than you may want to hear right now. I'll try to give you an abbreviated answer.
Q. If you could simplify it for me.
A. Okay. So there are three different ways at the minimum of administering intravenous ketamine. One is the one-day infusion followed sequentially by others; the other is the 24-hour continuous inpatient infusion that is not coma; and the third one is ketamine coma where the patient has a breathing tube put in the ICU for five days and undergoes very high dosage ketamine treatment with general anesthesia

simultaneously.
What is the most common are the daily infusions, and Dr. Schwartzman who wrote the first articles on this advocated 20 consecutive daily treatments at a relatively low dose that he was doing given the manpower he had administering it with him. There are very few -- I don't know if anybody still -- his studies demonstrated efficacy under those circumstances, but I don't know of anybody doing 20 days of infusion because it's cost prohibitive.
So the more common way, as I mentioned, Mr. Berman, is to do up to ten days of infusions. And I'll just tell what you our protocol is. We do a three-day trial, three consecutive days with escalating dosages on each day. And at the end of three days if on the fourth day the patient still appears to have some benefit a day after the third infusion, we consider then doing a full course of ten, but we don't want to obligate the patient to ten days if it doesn't look like it's going to work. Now, what I can tell you is that probably 80 percent -- and I don't have the exact number. But the vast majority of patients after the three-day infusion proceed to the ten days with the infusion.

Now, what the literature shows is, if you have a successful ketamine treatment -- and in our practice it would be the ten-day course -- that 50 percent of the patients have sustained benefit so that they never have to get any ketamine again. And the remaining 50 percent usually require booster infusions, which the longest -- well, that can be either monthly or every three months for years.

Q. Let's just talk about that sort of common example of ketamine treatment that works, the ten-day treatment. Do you have knowledge of the reasonable and customary type of cost of that ten-day ketamine treatment?

MS. HAY: I'll object to form and --

THE WITNESS: Yes.

MS. HAY: Just one second. I'll object to form and documentation given the doctor's locale, but you can go ahead and answer, Doctor.

THE WITNESS: Yes, I see variability between 500 and $2,500 per infusion.

BY MR. BERMAN:

Q. And I know that you talked about your understanding of these costs as an expert in this field. Would your understanding of the usual and

reasonable costs, the reasonable charges differ between California and Illinois and New York and all over the country?

A. The problem is, Mr. Berman, this is not something I have the opportunity to review because none of the guidelines for treatment of any kind of problems aside from depression -- well, none of them -- no guidelines include ketamine infusions for treatment of pain, headaches, or depression, no guidelines do. So insurance companies tend not to pay for it except by exception, and I've not had the opportunity ever to review billing for that. But I speak at ketamine conferences, and I speak to the people who are the active ketamine practitioners in the country. And I have an idea about what people charge.

Q. And that's throughout the country, right?

A. Yes.

Q. So for the DRG you're familiar with what people charge throughout the country, correct?

A. Yes.

Q. Understood.

I'm going to switch gears for just a moment. I'm finished talking about the ketamine for now. Now

I'm going to switch gears and ask you about diabetic neuropathy. I know some of your opinions in this case relate to diabetic neuropathy. Is it your opinion in this case that Mr. Narsimhan's symptoms in his right lower extremity relate to diabetic neuropathy?

A. Yes.

Q. And you've treated diabetic neuropathy pain and symptoms before, right?

A. Right. I'm a board-certified internist, and I have treated diabetic neuropathy and diabetic neuropathic pain long before I ever became an anesthesiologist and subsequently became a pain physician. So I was actually an attending physician in internal medicine, practiced internal medicine.

Q. And that's good. That background's important because the question I have is, how do signs and symptoms of diabetic neuropathy differ from signs and symptoms of CRPS, if at all?

A. Well, the symptoms are the same predominantly. The signs can be different. Both can get thinning skin certainly. Both can get peripheral hair changes. With diabetic neuropathy, there are other things that can simultaneously be occurring that can cause compromises in calculation, and that's

actually very common. And sometimes the compromise in circulation can create pain that's as bad as the peripheral neuropathic pain. In many ways they're similar, but you can even get sometimes the trophic changes in diabetic peripheral neuropathy. You can certainly get swelling in diabetic -- well, you can get swelling in diabetes where the extremities are involved, whether it's the diabetic peripheral neuropathy that's causing that problem or the diabetes that hasn't been well controlled. So I think that's -- we can dig in a little deeper later, but I think that should probably be telling you what you want to know.

Q. Yes, yes. The reason I asked you the initial question is, I'm wondering in your practice or in your work as an expert witness, have you seen times when diabetic neuropathy has been confused for CRPS and vice versa where CRPS has been confused as diabetic neuropathy?

A. Actually in my neuropathy, which is far more limited than my clinical practice, I have not seen that before. But it's actually not uncommon for patients to get referred to me from the community where somebody thinks the patient has CRPS, but, in

fact, they don't. And it's a substantial percentage -- although 80 percent of the patients that I see in my practice are referred to me for potential diagnosis of CRPS, a significant percentage of them don't have CRPS.

Q. Just to make sure -- just so I'm asking the right question, Doctor, I want to make sure I understand you. In your practice have you seen times when other doctors have diagnosed CRPS when, in fact, the actual diagnosis should have been diabetic neuropathy?

A. Yes.

Q. Have you ever seen times when doctors have diagnosed diabetic neuropathy when, in fact, the diagnosis should have been CRPS?

A. Yes.

Q. You've seen both, okay.

And in this case, in this Narsimhan case, you've seen doctors such as Dr. Buvanendran, Dr. Saeed, Dr. Joshi, their diagnosis in this case that Mr. Narsimhan had right lower extremity CRPS; you've seen that, right?

A. They have said that, yes.

Q. And in your opinion, in fact, the diagnosis

shouldn't be CRPS; it should be right lower extremity diabetic neuropathy; is that correct?

A. DPNP, yeah. More than just diabetic peripheral neuropathy, but diabetic peripheral -- we call it DPNP, diabetic peripheral neuropathy pain.

Q. DPNP?

A. DPNP.

Q. Got it, okay.

And in Mr. Narsimhan's situation, in his case, in your opinion, Doctor, after reviewing the entire record, what brought upon the symptoms of his DPNP?

A. The diabetes out of control.

Q. When did the diabetes become out of control such that the DPNP began?

A. Well, he had DPNP treated by Dr. Farbman in bilateral upper extremities for quite a period of time preceding the incident at Lowe's. And what's really important to understand, Mr. Berman, is that diabetic peripheral neuropathy and DPNP both tend to show themselves in the longest axons. Axon being a nerve, okay. And so it's usually more common to see it in the legs first than the arms, but if you have it in the arms, it usually shows up in the legs shortly

thereafter because the legs have longer nerves than the arms do.

And, you know, just for you to understand, you know, you don't get DPNP in your chest wall where the nerves are very close -- you know, where they come out is very close to where they wind up. You don't get DPNP on your lips. But you do get DPNP in your hands and feet very commonly for people who have uncontrolled diabetes.

Q. And from reading the records that reflected that at the time just prior to the incident Mr. Narsimhan was being referred to the neurologist Dr. Farbman for bilateral wrist carpal tunnel syndrome. Is that what the records shows?

A. I don't remember that that was the only thing, and I don't remember that the EMG necessarily showed that.

Q. I'm not saying what the actual diagnosis was. I'm saying that's what he was referred to Dr. Farbman for.

A. I don't recall that. We would have to find the exact time and date of the note, and you can put it up on the screen to show me that. Because that's not what I remember, but I won't swear to it.

Q. All right. In your opinion, however, as of July 2016 and prior even to that, is it your opinion that Mr. Narsimhan did not have carpal tunnel syndrome in his wrists?

A. Well, you said wrist, and it's unusual to develop bilateral --

Q. Wrists, plural.

A. Okay. It's unusual to develop bilateral carpal tunnel syndrome simultaneously, but usually one side is predominant. And looking at the pictures that he drew during that time interval, it sure looked like there was asymmetry.

Q. So your opinion was -- what was the cause of the bilateral wrists, plural, pain?

A. Diabetic peripheral neuropathy unless I see records that are to the contrary.

Q. An EMG was done of the upper extremities, right?

A. Correct.

Q. What did that find?

A. I'd have to look it up. I didn't commit everything to memory. But I do know where it is.

Okay. It does find bilateral median moderate neuropathy.

Q. Meaning?
A. That means that the median nerve is being compressed.
Q. Consistent with carpal tunnel syndrome?
A. Yes.
Q. And not consistent with DPNP in the wrist, correct?
A. Correct.
Q. And also the right lower extremity was examined in the EMG, and there were no positive findings, were there?
A. Right lower extremity -- no, there wasn't clinical correlation advised.
Q. So to be fair and to be accurate, the EMG that was performed in July about a month after the occurrence at Lowe's found consistent findings of carpal tunnel syndrome in the bilateral wrists and no consistent findings of DPNP in the right lower extremity; is that correct?
A. No polyneuropathy in the lower extremity.
Q. So what I said, is that correct?
A. Well, I just clarified it a little bit, so I stick with what I said.
Q. Well, would DPNP be evidenced by

polyneuropathy in the lower extremity?
A. It would be one sign of it, yes.
Q. So the EMG that was done of Mr. Narsimhan's right lower extremity of July 26, 2016, was not consistent with DPNP in the right lower extremity; is that correct?
A. Correct.
Q. You also said -- and if I understand what you said -- and I believe I heard what you said -- the way DPNP forms is when diabetes becomes out of control; is that right?
A. Correct.
Q. Can you explain to me, when you say "out of control," exactly what you mean by that?
A. What I mean by that is that you have elevated blood sugars chronically.
Q. You said elevated blood sugars, chronic something, and I didn't hear the rest.
A. Chronically.
Q. Chronically?
A. Yeah.
Q. Anything else?
A. That's what diabetes out of control is.
Q. Okay. And the way to test for elevated blood

sugars is an A1C test; is that right?
A. Hemoglobin A1C.
Q. Yes?
A. Yes.
Q. And I think this was discussed in Dr. Matiwala's deposition that if an A1C level was over 7, it means that the diabetes can become out of control, but under 7 the diabetes is in control. Do you remember him saying that?
A. Yes.
Q. Do you agree with that, that's accurate?
A. People draw the line at different places, but I think that's a reasonable place to draw the line.
Q. And I believe in Dr. Matiwala's records, you reviewed all of his A1C recordings?
A. Yes.
Q. So prior to the incident in Lowe's, we have at least I guess two visits to Dr. Matiwala. You saw that, right, in the records?
A. Matiwala.
Q. Matiwala.
A. Yes.
Q. You saw in the records that there was a visit of February 2016 and May 31st of 2016 prior to the

incident at Lowe's, correct?
A. Correct.
Q. And then there was a visit with Dr. Matiwala in September of 2016 that's after the incident at Lowe's, correct?
A. Right.
Q. You saw that initially the A1C in February of 2016 was 8.5, and you consider that essentially out of control, correct?
A. That's correct.
Q. And then the next visit of May 31st, 2016, so a little less than a month before our incident of June 25th, 2016, the A1C level was 6.6. Would you consider that A1C level an indication of under control diabetes?
A. That's borderline under control.
Q. It's under 7, so therefore it's within the in-control level?
A. It's high under control.
Q. What would you consider high then?
A. What I'm saying -- you know, if it's 0.5 higher, you would say it's out of control. So it's borderline. That's what it is.
Q. Would you agree that -- in your opinion,

would you think that a person who has a 6.6 A1C would be at risk for having diabetic peripheral neuropathy with pain, DPNP?
A. If they maintain that, no.
Q. September of 2016 the A1C level was 6.7, so point one higher. Would that person at that time be susceptible or at risk for DPNP?
A. Marginally. Likely not, but not impossible.
Q. So what was it about the A1C levels in May and September of 2016 that indicate to you that as of June 25th, 2016, Mr. Narsimhan was complaining of right lower extremity diabetic neuropathy with pain?
A. Say again, please.
Q. What is it about the A1C levels of Mr. Narsimhan in May of 2016 at 6.6 and September of 2016 at 6.7 that indicate to you that after 6/25/2016 Mr. Narsimhan was complaining of DPNP in his right lower extremity?
A. Those particular ones would not necessarily suggest that he would get diabetic peripheral neuropathy, but he did have others previously that -- again, I pointed out that Dr. Matiwala pointed out that his insulin dosage had not changed for years, and that he needed -- I mean, he really needed dietary

counseling, and that he was not monitoring his glucose. Now, those two isolated ones I completely agree with you, Mr. Berman, likely would not put him at risk, but we really don't know what went on long before that. We don't really know so much about what happened subsequently as well.
Q. If a person who has diabetes, the diabetes gets out of control causing DPNP, can one of the treatments for that DPNP be getting diabetes within control?
A. It won't get the neuropathy better. It will prevent it from progressing.
Q. When did the DPNP symptoms start for Mr. Narsimhan?
A. I don't know.
Q. Dr. Matiwala testified that throughout his time treating Mr. Narsimhan that Mr. Narsimhan had type 2 diabetes mellitus without complications. Did you see that?
A. Yes.
Q. Would a complication of diabetes be this DPNP that we're discussing?
A. Yes.
Q. So according to Dr. Matiwala's records and

his deposition, Dr. Matiwala, the doctor who was treating Mr. Narsimhan for the diabetes, felt like the diabetes was without complication, therefore without DPNP, true?
A. Yes.
Q. And also, Dr. Matiwala performed diabetic foot exams. You saw that, right?
A. Yes.
Q. Is part of the reason why a doctor does diabetic foot exams is to try to see if there is any indication of DPNP or diabetic peripheral neuropathy?
A. No.
Q. Okay. So a diabetic foot exam, in your opinion, has nothing to do with finding whether a person has diabetic peripheral neuropathy in their feet?
A. Correct. I shouldn't say -- it's not the main reason they do it.
Q. But it can help to find -- strike that.
Diabetic foot exams can help find DPNP in a person's feet?
A. Correct. Just so you know, that's not the principal reason that that exam is done.
Q. It doesn't have to be the principal reason.

It can be an ancillary reason. Dr. Matiwala consistently performed diabetic foot exams and found them to be negative, and, in fact, in his deposition, Dr. Matiwala felt that based on the diabetic foot exams there was no indication of diabetic peripheral neuropathy in Mr. Narsimhan's right lower extremity. Did you see that?
A. I don't remember that.
Q. Would you disagree with that testimony if it was there?
A. Well, if the testimony is there, I wouldn't disagree with what his opinion is.
Q. Switching gears for just a moment.
I think you saw in the record -- correct me if I'm wrong, but I think you saw in the record that prior to the incident of June 25th, 2016, at Lowe's, Mr. Narsimhan was very active, ran on the treadmill, did 5Ks, that kind of thing. Did you see that?
A. Yes. According to him, yes.
Q. Is that something that if a person has diabetic peripheral neuropathy in their feet or foot that this would make running on the treadmill and performing 5Ks difficult to do?
A. Yes.

Q. So do you see any indication in the record prior to June 25th, 2016, that Mr. Narsimhan had diabetic peripheral neuropathy in his right lower extremity?
A. No.
Q. You saw in the record I believe that because of the pain and discomfort in Mr. Narsimhan's right lower extremity that he was less physically active, correct?
A. That's what he says, yes.
Q. Obviously pain in the lower extremity can cause people to be less active, run less, be on their feet less, walk less, that kind of thing, agree?
A. Yes.
Q. Dr. Matiwala was asked on page 41 of his deposition whether the symptoms of right lower leg burning pains, if he was able to eliminate those as diabetic complications, and he said yes, he would. Did you see that in the deposition?
A. Yes.
Q. Do you disagree with Dr. Matiwala, the doctor who was treating Mr. Narsimhan for his diabetes?
A. Hold on a second.
Q. It's page 40, line 23 to page 41, line 3. It

diabetes?
A. No.
Q. If Dr. Matiwala says that he was able to get the diabetes under control, yet you in your opinion testified that the diabetes was out of control which was what caused the DPNP; is that correct?
A. That it had not been under control.
Q. When was the diabetes not under control such that it caused the DPNP in Mr. Narsimhan's right lower extremity?
A. Say the question again, please.
Q. Yes. The question is when was the diabetes out of control such that it caused DPNP in Mr. Narsimhan's right lower extremity?
A. During the time before he started seeing Dr. Matiwala or at the beginning.
Q. We just went over this, Doctor. In the beginning when Mr. Narsimhan started seeing Dr. Matiwala in May and September, in those two visits it was under 7, the A1C was under 7. So that's an indication of the diabetes being in control; you agree with that, right?
A. I think when he first started seeing Dr. Matiwala, that the diabetes was above 7.

says, "Okay. And these symptoms that he's reporting on a consistent basis, were you able to eliminate those as diabetes complications?" Answer: "Yes, I would based on the EMG conduction study he'd undergone." Do you see that question and answer?
A. I do, yes.
Q. Do you disagree with Dr. Matiwala?
A. No.
Q. On page 45 of Dr. Matiwala's deposition, he was asked at line 10: "And throughout the time you were seeing Mr. Narsimhan, you were able to get his diabetes under control, correct?" Answer: "That is correct."
A. You said 45, 10. I'm on 45, 10. I don't see that. Oh, okay.
Q. Should I reread it?
A. Yes. Okay, yes.
Q. And the question was: "Throughout the time that you were seeing Mr. Narsimhan, were you able to get his diabetes under control, correct?" Answer: "That is correct." Do you see that?
A. Yes.
Q. Do you disagree with Dr. Matiwala, the doctor who was seeing and treating Mr. Narsimhan for his

Q. Yes. So are you saying that in February 2016 the diabetes was out of control such that it caused the DPNP to begin in the right lower extremity?
A. It put the patient at risk.
Q. So when was the diabetes out of control such that it actually caused, not put him at risk, but actually caused the DPNP to begin?
MS. HAY: Just object to asked and answered. If you want to answer again, Doctor, go ahead.
THE WITNESS: He was at risk in February of 2016.
BY MR. BERMAN:
Q. I know, Doctor, but you said, in your opinion, Mr. Narsimhan has DPNP in the right lower extremity; is that right?
A. Yes.
Q. When was the diabetes out of control such that it caused that to actually begin, the DPNP in the right lower extremity?
MS. HAY: Objection, asked and answered. You can answer again, Doctor.
THE WITNESS: I think he was set up for it in February '16.

BY MR. BERMAN:
Q. He was what?
A. A setup.
Q. Set up?
A. Yeah.
Q. But the DPNP didn't start in February 2016, did?
A. We don't know.
Q. You don't know?
A. Likely it did not.
Q. So do you know when the DPNP started?
A. No.
Q. The symptoms of DPNP?
MS. HAY: Objection, asked and answered three times.
BY MR. BERMAN:
Q. Doctor, is it accurate to say that diabetic peripheral neuropathy typically is seen bilaterally?
A. Yes.
Q. And in this case it's your opinion that the DPNP is exclusive to the right lower extremity of Mr. Narsimhan, correct?
A. Yes. Well, we don't know exclusively.
Q. What do you know?

A. That on his examination -- well, we know that nobody ever did an distracted examination on this gentleman who makes certain accusations that I know have significant discrepancy. And I did not see, Mr. Berman, one distracted examination on this man who complains of pain when you look at him and you touch him and he sees you, but he doesn't consistently complain of pain when you distract him.
Q. Which doctor indicated that Mr. Narsimhan does not complain of pain when you touch his right lower extremity when he's distracted?
A. Nobody ever did a distracted examination, which an expert in CRPS would always do.
Q. Because no one ever did that test, are you assuming that it would be negative for CRPS?
A. No, I'm only -- we're not talking for CRPS. We're talking for pain. We truly don't know what it would have shown. The only place there's a data point with a distracted exam is my exam where you were there.
Q. So are you assuming that because Dr. Farbman, Dr. Saeed, Dr. Buvanendran, Dr. Matiwala, all these doctors who didn't do a distracted exam for pain that it would have been negative when those doctors saw and

examined Mr. Narsimhan?
A. What I'm saying is that we really don't know what a distracted exam would have shown. That's all I can say. We know that my distracted exam showed inconsistency. They never did. And this is a guy who has a motivation to have pain or to describe pain.
Q. That's true for any plaintiff in the world, right?
A. It's true. Well, not all of them complain about pain. They complain about different things.
Q. Any plaintiff who is complaining of pain has a motivation to say they have pain because in your opinion they've got a case, right?
MS. HAY: I'm sorry. I didn't hear the end of that question, Steve. Can you repeat it?
MR. BERMAN: Because they have a case.
MS. HAY: Thank you.
THE WITNESS: Any patient that has a complaint of CRPS has motivation to demonstrate they have pain.
BY MR. BERMAN:
Q. You didn't diagnose secondary gain in Mr. Narsimhan's case, did you?
A. I don't like to go into secondary gain. I

just see marked discrepancy here.
Q. I'm just asking, did you make the diagnosis or not?
A. What do you mean?
Q. Did you make a diagnosis of secondary gain in Mr. Narsimhan --
A. I don't make a diagnosis of secondary gain. I don't make it.
Q. Let's talk about your examination of Mr. Narsimhan, and that would be relating to the report of 1/21. Do you have the report in front of you, or do you want me to put it on the screen?
A. I can put it up very quickly so I can have it in front of me.
Okay. We are talking about the independent medical examination performed on 1/15/21; that's what we're talking about at the moment, correct?
Q. We're talking about the examination 1/15/21 that you performed in Chicago near O'Hare.
A. Yes.
Q. You called it an independent medical evaluation. I don't call it an independent medical evaluation because at that time you were retained by the defense to perform the examination, correct?

A. You can call it what you wish. I do it as an independent exam.
Q. I hear you. But at the time you examined Mr. Narsimhan, you had been retained by the party that Mr. Narsimhan had a claim against, right?
A. Right. And it's my job to do an objective exam, which is why I call it independent.
Q. But the answer to my yes is yes; is that correct?
A. The answer to that question is yes.
Q. And during that medical examination, you spent a total of about an hour with Mr. Narsimhan, correct?
A. Yes.
Q. You told Mr. Narsimhan at the time that you were retained by the other side; you told him that, right?
A. That I was retained by the defense, yes.
Q. And you told him that there was no physician-patient relationship generated from this examination; it was for medicolegal purposes only, correct?
A. Correct.
Q. During the examination, you took a history,

then you did an examination for symptoms and signs of potentially indicating CRPS, right?
A. Well, you don't do an examination for symptoms. You only do an examination for signs.
Q. So you did a history for symptoms, right?
A. Correct.
Q. You asked the patient -- you asked the client. I'm sorry. At the time of your examination, you asked my client what his symptoms were, right?
A. Correct.
Q. And then you performed an examination looking for the signs that might be related to CRPS, right?
A. Correct.
Q. And the signs can be objective signs, right?
A. The exam was the objective signs, correct.
Q. So things like swelling, the way the skin looks, hair changes, moisture, sweating, those are things that can be observed by the examiner, correct?
A. Correct.
Q. And those can be documented at times photographically, those signs, correct?
A. Excuse me? Say again.
Q. Some of those signs upon examination can be documented photographically because they're objective,

correct?
A. Correct.
Q. In your examination of Mr. Narsimhan, you took no pictures; is that correct?
A. That is correct.
Q. So to be fair, whether Mr. Narsimhan had any signs relating to a diagnosis of CRPS would not be documented one way or the other by use of photographs from your examination, true?
A. It could -- well, some of them are -- you can't diagnosis temperature with photographs. You can diagnosis tremor, hypertonia, spasticity with photographs. What you can diagnose with photographs are changes in the hair. Edema is hard because the way you diagnose edema is by looking for pitting, and you can't do pitting in a photograph. So what you can see are changes in the hair, skin, nails, or color changes.
Q. To be fair, Doctor, all I'm asking is, you took no pictures during your examination of Mr. Narsimhan to document the existence of or lack of signs relating to a diagnosis of CRPS, true?
MS. HAY: Objection, asked and answered. You can answer, Doctor.

THE WITNESS: Well, the only answer I give is that I did not take pictures, because I don't agree with what followed.
BY MR. BERMAN:
Q. In your examination of Mr. Narsimhan, it said, "Reflexes could not be performed at the ankle." Why is that?
A. Because of pain that he would have experienced based on what he was saying.
Q. That's related to the right ankle, correct?
A. Correct.
Q. The ankle is the one that's at issue in this case, correct?
A. Correct.
Q. Same with sharpness. It says, "Sharpness examination was deferred in the right leg, as mentioned above." That's because it would have caused significant pain in the right lower extremity, correct?
A. Because of what he said, yes.
Q. It says, "Calcaneal reflexes were deferred secondary to prevent pain." Same thing, correct?
A. Correct.
Q. That was only on the right side?

A. Correct.
Q. It says, "Dorsiflexion of the right foot was deferred." What does that mean?
A. It means that I didn't ask him to bend his foot toward the ceiling.
Q. And it says, "deferred." Why was that in this case?
A. Same thing, because he was complaining of pain.
Q. It was in the right affected leg as opposed to --
A. I was trying to avoid the pain. I didn't want to cause him any pain. And you were there, and you saw that I wasn't trying to cause him any pain or did I cause him any pain.
Q. I'm not accusing you of purposefully trying to cause him pain. I'm saying that -- I think you're agreeing with me that you deferred dorsiflexion of the right foot test because you felt that could cause him increased pain in his right affected lower extremity, correct?
A. If I recall correctly, I did ask him, and he said it was too painful to do, so we deferred it. So he never attempted it.

Q. And let's go to page 4 of your report where you talk about the requirements for CRPS. These are the Budapest requirements you're referring to specifically, right?
A. Yes.
Q. One was pain out of proportion for the original injury. It says, "Mr. Narsimhan endorses this." That means -- well, explain to me what you mean when you say, "Mr. Narsimhan endorses this."
A. Well, that's what he says, so I counted that as positive. When I do evaluations whether I am retained by the plaintiff or the defense, I don't always say that the plaintiff endorses it, but he endorsed it.
Q. Endorses means is positive in that requirement No. 1 is met?
A. I guess if you want to say it in more simple language, that's what he says. I mean, I think "endorses" is clear, but if you have trouble -- that's what he says.
Q. So requirement No. 1 of the Budapest test for CRPS is met, correct?
A. Right.
Q. Requirement No. 2 of the Budapest test for CRPS is, "Symptoms described by the patient from three out of the four designated diagnostic categories." Mr. Narsimhan endorses this as well, correct?
A. Correct.
Q. So requirement No. 2 for the Budapest test for CRPS is met, correct?
A. Correct.
Q. Requirement No. 3, that's the signs we were talking about upon examination. Two of the four designated categories is required to have been met. This one was not met, correct?
A. No. 3 was not fully met, right.
Q. So requirement No. 3 was not fully met because only one but not two of the criteria were met; is that accurate?
A. Categories.
Q. Categories. Accurate?
A. Yes.
Q. All right. So sensory was met after vasomotor, sudomotor/edema, motor/trophic, correct?
A. Correct.
Q. So the vasomotor are things such as -- let me check my notes, Doctor. Vasomotor are things like skin color changes, temperature differences, right?

A. Right.
Q. Sudomotor/edema are things like sweating or excessive sweating, correct?
A. Sweating, goose bumps.
Q. Motor/trophic changes are things like decreased range of motion, weakness, spasticity, tremor, dryness around the skin, right?
A. Well, a certain kind of dryness of the skin, but yes, it would be scaly skin.
Q. Scaly, okay.
You saw in Dr. Buvanendran's notes that he noted upon examination that Mr. Narsimhan had color changes to his right and left; you saw that, right?
A. Right and left?
Q. Yes.
A. Okay.
Q. I'm just asking about Dr. Buvanendran's records that I know you reviewed.
A. If it's right or left, it doesn't mean anything. Right and left, it doesn't mean anything to me.
Q. All right. Well, let's be clear then. Dr. Buvanendran noted in his records that there was a color change to the right lower extremity; there was

temperature difference between the right lower extremity and left lower extremity. Do you see that?
A. Well, I don't know what page you're on, which document.
Q. Dr. Buvanendran's records.
A. Why don't you put it up on the screen.
Q. I don't have it on the screen. Dr. Buvanendran's record -- it's also on page 49 and 50 of his deposition if you want to look it up, if you have access to that as well.
A. Well, I do.
Q. It says here there's change to the nailbeds. What is that considered? Is that a trophic change or sudomotor change, vasomotor?
A. It's not sudomotor.
Q. I'm sorry. Say that again.
A. It's not a sudomotor change. It could be a vasomotor change if it's described as such.
Q. So in Dr. Buvanendran's records and in his deposition on page 49 to 50, he describes on examination observing color change to the right lower extremity, temperature differential, and changes to the nailbeds in the right. Do you see that?
A. Trophic changes to the nailbed, yeah, he

does.
Q. So that would -- in terms of signs on examination, that would meet requirement three for the Budapest criteria, correct?
A. He met it on that date, yes.
Q. In terms of symptoms, Dr. Buvanendran noted hypersensitivity, the increased sweating, swollen, so edema. Those would be signs -- I'm sorry. My mistake. Those would be symptoms consistent with meeting requirement two of the Budapest -- let me back up, Doctor. I screwed that up entirely.
Dr. Buvanendran in his records and his deposition indicated that there were certain symptoms he elicited during his examination or his history of Mr. Narsimhan which included burning, stabbing pain in the right lower extremity, swollen right lower extremity, color change to the right lower extremity, hypersensitivity to the right lower extremity, and increased swelling in the right lower extremity. Do you see that?
A. Is that in his deposition or that's in his --
Q. In his records.
A. I'm looking at his record now. What date?
Q. The first date of examination.

A. 10/19, something like that?
I have 1/13/20, 2/14/20, 1/21/20. That's a follow-up.
Q. 7/30/19, try that one.
A. When?
Q. 7/30/19. Okay?
A. Okay, here, 7/30/19. Okay, I see it.
Q. Okay, there we go.
So in Dr. Buvanendran's record of his examination and history that he took of Mr. Narsimhan on 7/30/19, the requirement Nos. 2 and 3 of the Budapest criteria have been met, correct?
A. Yes.
Q. Requirement one would be met as well because that's ongoing pain that is disproportionate with the inciting event, correct?
A. According to this.
Q. And I think we talked about this earlier, so what I'm wondering is -- I think you said that signs relating to CRPS can wax and wane, and people can have good days and bad days with regard to those signs, right?
A. True.
Q. And do you know, maybe you don't know, but do

you recall that Mr. Narsimhan when he saw you, when you were asking him questions, he told you that today, when he was seeing you in the examination, was a much better day than usual? Do you recall that?
A. I don't vividly recall it, but I wouldn't say it didn't happen.
Q. So hypothetically, if Mr. Narsimhan was having a much better day on the day you saw him, which was January 15th, 2021, that means he may have less signs of CRPS than other days, correct?
A. That's true.
Q. Do you disagree with Dr. Buvanendran that when Dr. Buvanendran saw Mr. Narsimhan that Mr. Narsimhan met the requirements of CRPS?
A. I have an issue, but as documented on that visit, it would fulfill the diagnostic criteria for CRPS.
Q. So Dr. Buvanendran's examination and history and findings of Mr. Narsimhan would be consistent with fulfilling the Budapest criteria for CRPS. True so far?
A. Yeah, I mean, 7/30/19. Now, where I have issue with Dr. Buvanendran is --
Q. Before you give me your issue, answer the

question.
A. Okay. That exam as he documented would be consistent with meeting the Budapest criteria for diagnosis of CRPS.
Q. Now tell me your issue.
A. My issue is that all his exams have the exact same temperatures at the same places, have the same misspelling in words that he used like gauze, and it kind of -- it compromises the credibility of this whole situation if he's cutting and pasting. There are three exact exams on different dates where he has temperatures measured at 1.5 degrees to the calf; medial area, 2.5 degrees; 2.2 degrees at the foot. And I can tell you that way, way, way beyond medical probability that the temperatures -- three temperatures at three different places to be exactly the same on three different days is virtually impossible. Statistically way, way less than 1 percent. Within medical probability, within medical reason, within medical anything, you cannot have that, and here's a guy on three different occasions reporting the exact same thing. That's what I have an issue with.
Q. I understand that. Here's my question,

though, generally for you: Can a patient meet the Budapest criteria for CRPS on one examination, but then possibly not meet the Budapest criteria on the next examination --
A. Yes.
Q. -- or does it have to be -- okay.
A. I think I answered that question to you a few times already.
Q. Oh, good.
So as a treating doctor, if you have a patient who at times doesn't meet the Budapest criteria but had previously met the Budapest criteria, do you change the diagnosis?
A. Actually, what I say under those circumstances is that there are documented diagnoses of CRPS in the chart, and that on my exam it appeared that the CRPS is in remission if there were CRPS before based on credible examinations.
Q. That makes sense. But you say, "in remission," which does not change the diagnosis. It continues the diagnosis, but it's just the symptoms are in remission?
A. If they are credible exams, yes.
As a matter of fact, last week I did exactly

that on a plaintiff's exam.
Q. I'm certain that you reviewed Physical Therapist Schwartz's records and Physical Therapist Fischer's records, correct?
A. I don't know that I have Fischer's records. I reviewed Schwartz's records.
Q. You don't have Fischer's records?
A. I don't think I do.
Q. Maybe I'm mistaken. I thought you had them, but maybe not.
A. I think I told you at the beginning I didn't.
Q. I'm almost certain you told me you did not have his deposition. I know that for a fact. But I thought you had his records. Maybe that's where I was mistaken.
A. I don't recall the name Fischer as I was doing it. Do you know the facility where I could look for it?
Q. Yes, I think I do.
A. Hold on. I can do a search. Fisher, F-i-s-h-e-r?
Q. I have it, F-i-s-c-h-e-r.
A. Wait. We have to know for sure which way.
Q. F-i-s-c-h-e-r, Brian Fischer.

A. No items match the search.
Q. In your practice -- let me just ask you this way. I'm not worried about that at this time. I'm going to try to wrap up, if I can.
In your practice, at times do you prescribe physical therapy for patients with a diagnosis of CRPS?
A. Definitely.
Q. So physical therapy is one recognized method of treatment for CRPS, right?
A. It's one important component.
Q. Okay. And are there certain -- to your knowledge, are there certain physical therapists who seem to have more training in regards to treating CRPS patients than others?
A. For sure.
Q. Dr. Buvanendran, in fact, prescribed physical therapy for his patient Dr. Narsimhan. You saw that prescription, right?
A. You said Dr. Narsimhan. Is he a doctor?
Q. Did I mess up the question? I had it right for me. I don't know about you.
Dr. Buvanendran prescribed physical therapy to treat the right lower extremity symptoms in his

patient Mr. Narsimhan, right?
A. Yes.
Q. You don't have a problem with that prescription for that type of treatment for those symptoms, do you?
A. No. I'm very careful with how I prescribe it myself, but I don't know his infrastructure to be able to know if I like the way he prescribed it or not. But it's the right thing to do.
Q. And Physical Therapist Fischer -- let me back up. Physical Therapist Schwartz, who I know you did review her records and her deposition, indicated upon her initial examination of 1/13/20, she wrote down "53-year-old male who presents with signs and symptoms consistent with referring diagnosis." Do you see that?
A. Yes. Well, I don't see it.
Q. Well, referring diagnosis, but take out the words CRPS right lower extremity, right?
A. Here, I have Lisa Schwartz in front of me now.
Q. Take a look at 1/13/20. Its page 97 of the records if it helps at all.
A. Okay. So she says -- hold on. It looks like

I have 1/13/20, page 1 of 4, and then I don't have pages 2 of 4. I don't have pages 2 of 4, so I don't have what you're quoting.
Q. Do you have the diagnosis portion of that where it says "Outpatient Physical Therapy Initial Evaluation"?
A. Excuse me. I have page 1 of 4, which doesn't go down to that. Then pain location, pain range, and then it goes right into -- unfortunately, it goes into the exam of 2/14. So I only have one page of that. I have plaintiff's Bates page 94. Is that what you're looking at?
Q. No. No, I'm looking at the records themselves. Maybe you're missing them. But the initial evaluation by Lisa Schwartz was on 1/13/2020.
A. Which I have 1/13/2020. I have that.
Q. That's what I'm looking at.
A. I only have one page of it.
Q. Do you see on 1/13/2020 Lisa Schwartz's records show a diagnosis CRPS --
A. I don't think you're getting what I'm saying. She had four pages of notes. I only received one.
Q. I'm asking which one? Do you have a diagnosis on one page?

A. Page 1 of 4, the last thing is, "patient goes".
Q. So do you know what the patient, Mr. Narsimhan, was -- what diagnosis Mr. Narsimhan was referred to Lisa Schwartz to treat?
A. She says the diagnosis was made in 2019. Started with PT immediately after he had his first injections.
Q. So we don't know what the diagnosis was he was referred to her for?
A. Well, no. It said there was a diagnosis made in 2019.
Q. It says, "a diagnosis." What was the diagnosis?
A. No, it says, "diagnosis CRPS in 2019." You should be able to find that in the 1/13.
Q. All right. So Mr. Narsimhan presented to Lisa Schwartz for physical therapy on 1/13/2020 with a diagnosis of CRPS right lower extremity, agreed?
A. That's what Dr. Buvanendran sent him to her for.
Q. And the assessment that Lisa Schwartz stated in her records was "Patient is a 53-year-old male who presents with signs and symptoms consistent with

referring diagnosis."
A. Okay. Please read her physical examination to me because I don't have it.
Q. I'm just asking you if you've seen the assessment or not.
A. Well, I've told you that I only have page 1 of 4 of that. I've said it like three or four times.
Q. So you're telling me you don't have the assessment in that?
A. I keep telling you the same thing. Yes, I do not have the assessment. I only have Bates page 94, page 1 of 4 of Lisa Schwartz's 1/13/20 note, and I'm missing pages 2, 3, and 4. It didn't come to me on that PDF.
Q. Did you ever ask the attorney who sent you the records to give you more complete records for Ms. Schwartz?
A. I did not.
Q. If you're missing certain portions of the records, wouldn't that be relevant to your opinions?
A. It would.
Q. Then you're missing certain portions of Linda Schwartz's examination and assessments of her patient Mr. Narsimhan, right?

MS. HAY: I think it's Lisa Schwartz, by the way, Steve.
BY MR. BERMAN:
Q. Lisa Schwartz.
A. It is. It's Lisa Schwartz.
Q. With that caveat, can you answer my question?
A. The answer is, it would have been better if I had asked for those records, but I missed that in the plethora of records that I was reviewing.
Q. Let me switch gears. It is accurate you commonly don't see nerve damage visible in patients diagnosed with CRPS?
A. Can you repeat that, please?
Q. Is it accurate that you commonly don't see nerve damage visible in patients diagnosed with CRPS?
A. In CRPS 1.
Q. In CRPS 1, that's true?
A. That's true in CRPS 1.
Q. CRPS 2 is when there's actual damage to a nerve, correct?
A. Correct.
Q. You saw Dr. Saeed in her records and deposition that she came to the conclusion based upon her examinations of Mr. Narsimhan that her diagnosis

was CRPS right lower extremity, correct?
A. Right. And that was, in 7/7/18, two years --
Q. I know when it was. Just answer my question. That's okay.
A. I answered it.
Q. And you disagree with that diagnosis, right, by Dr. Saeed?
A. I'm having trouble finding that note, but I would like to -- do you have that note in front of you?
Q. Not that I can put on the screen. I have it in paper.
A. I have a webcam myself. I can give it to you.
She makes a possible diagnosis of CRPS at that time, and I guess my question is, why would that happen two years after the incident?
Q. My question is, Doctor, do you disagree with Dr. Saeed's diagnosis of CRPS right lower extremity?
A. I don't have the note in front of me at the moment, and I can't commit.
Q. You can't say whether you agree or disagree with Dr. Saeed?
A. Until I have the opportunity to review her

note, I cannot do that. There are just so many records here.
Q. What about Dr. Buvanendran, Dr. Buvanendran made a diagnosis of CRPS right lower extremity; you saw that in the records, right?
A. Yes.
Q. Do you disagree with Dr. Buvanendran's diagnosis of CRPS right lower extremity?
A. I believe in his multiple duplicated evaluations, that they did provide diagnostic criteria for CRPS. Asked and answered.
Q. No, I know that you said that there was diagnostic criteria present for CRPS in Dr. Buvanendran's records. I'm simply asking, as a medical professional based on your review of the records, do you disagree with Dr. Buvanendran's diagnosis of CRPS right lower extremity for Mr. Narsimhan?
A. What I'm saying -- and I think I keep -- I mean, I don't know how I can say it differently. That his documentation supports a diagnosis of CRPS in the multiple duplicated evaluations that he put in his chart.
Q. So you agree with Dr. Buvanendran's

diagnosis?
MS. HAY: I'm sorry. Can you read that -- I missed that question, Steve, or can Ms. Court Reporter read it back?
BY MR. BERMAN:
Q. Sure. I'm simply asking, can you tell me you agree or disagree with Dr. Buvanendran's diagnosis?
MS. HAY: Hold on one second, Doctor. I'll just object to asked and answered. I think he's answered it already, but you can go ahead and answer, Doctor.
THE WITNESS: Well, clearly, Mr. Berman, I was not present at that exam. And what I'm telling you, Mr. Berman, is that his documentation if done accurately, even though I raise the question how three consecutive examinations could have the exact same data in them, but if he is documenting accurately in his three duplicated exams, then they do fulfill the diagnostic criteria for CRPS. And not being there, I cannot go further in what I have to say.
BY MR. BERMAN:
Q. So as a medicolegal consultant in this case, you can't state an opinion of whether you agree or disagree with Dr. Buvanendran's diagnosis?

A. I'm going to say the same thing. I wasn't there. What I can tell you is that he provided adequate documentation in his duplicated examinations to provide a positive diagnosis utilizing the diagnostic criteria of Budapest -- of the International Association for the Study of Pain for the diagnosis of CRPS.

Q. I know, but you weren't there for any of these doctors who examined Mr. Narsimhan other than yourself.

A. Correct.

Q. So despite that, you're giving opinions about the diagnosis for Mr. Narsimhan's pain even though you weren't present at the examinations of Dr. Saeed, Dr. Buvanendran, Dr. Matiwala, Dr. Farbman, Physical Therapist Fischer, Physical Therapist Schwartz, right?

A. I don't have Physical Therapist Fischer's notes at all, and Physical Therapist Schwartz, I don't have the salient parts of her notes. And on the others, the only thing I can opine on is whether they met the diagnostic criteria based on their documentation.

Q. It is a fair characterization to say that the only thing you can really opine on is whether the

records accurately documented the diagnostic criteria for CRPS on any given date?

A. That's what I'm telling you.

Q. So Mr. Narsimhan may have had the diagnostic criteria for CRPS on dates other than the documented dates of Dr. Buvanendran, but it wasn't properly documented, that's possible, fair?

A. Well, that's flipping it the other way. And what that's saying is, maybe people did completely inadequate exams on other days, and that's why they didn't come up with the diagnosis of CRPS. I think that's what you're trying to say.

Q. Have you ever seen any doctors who maybe aren't as familiar with the Budapest criteria as you who perform examinations of patients, and then maybe don't document the Budapest criteria as carefully as you?

MS. HAY: Can you read that back, please? That was a long question.

(Whereupon, the record was read as requested.)

MS. HAY: I'm just going to object to form, foundation and vague and confusing. But if you understand, you can answer that, Doctor. Go ahead.

THE WITNESS: I'm going to answer it, Ms. Hay, the way I want to answer it. You may not like the answer.

At least what I'm gleaning from what you're saying, Mr. Berman, is do I see people that make a diagnosis of CRPS but did not provide adequate diagnostic criteria to establish that diagnosis, and clearly I see that all the time.

BY MR. BERMAN:

Q. And do you see the opposite as well, Doctor, you at times see doctors who fail to recognize CRPS because they don't perform the Budapest criteria examination?

A. Yes, I see that, too.

Q. Okay. And in this case, Mr. Narsimhan saw Dr. Farbman and Dr. Saeed, and I think in your opinion, the Budapest criteria was not properly documented, correct?

A. Nobody ever -- I mean, Dr. Farbman's account from what I gleaned from reading his notes and the way he does things -- it appears he may have retired. I don't know. I got that impression from the chart. But I got the impression he was a competent neurologist that were CRPS present he would have

picked it up.

Q. What gave you that impression?

A. Because a competent neurologist should be able to do that.

Q. You think any competent neurologist in the world should be able to do that?

A. Well, should and does are two different things, but if it's a competent neurologist, "should" fits.

Q. How do you -- what makes you think that Dr. Farbman is such a competent neurologist that he should be able to perform a Budapest criteria examination and document it properly?

A. Well, that's a whole different thing. That's different than what you asked me, sir. What you asked me is would he be competent to be able to make a diagnosis, and documenting it is another thing. But based on the way his notes are written -- and believe me, I see the broad spectrum of notes. And based on the quality of his notes, it's my opinion that he's a competent neurologist. Now, I'm not there at his own institution, but he's not at a shabby institution either. That in a good institution somebody who keeps good notes, who doesn't copy his notes from visit to

visit verbatim is a competent neurologist.

Q. Is there any other reason other than doesn't copy his notes from day to day that indicates that Dr. Farbman is a competent neurologist capable of understanding and performing and documenting the Budapest criteria, anything else?

MS. HAY: Just object to misstating his prior testimony about his review of his record, but you can go ahead and answer, Doctor.

THE WITNESS: And, Ms. Hay, thank you, because I was going to use nonlegal words to say he was twisting what I was saying.

And the bottom line is, I'm not saying that he was competent to document the diagnostic criteria for CRPS, but he's competent to be able to make a diagnosis even if he doesn't document it properly or at the minimum -- and this is really important -- at the minimum raise in his differential diagnosis, which any competent neurologist would do, would raise the possibility of CRPS if it was present, and he did not do that.

BY MR. BERMAN:

Q. What about Dr. Saeed, did you get the impression that she was a competent neurologist to

make a diagnosis of CRPS even if she doesn't document the Budapest criteria properly?

A. I think she is competent to raise the question of CRPS, which is what most of the neurologists in my community do. They don't fully establish a diagnosis. They raise it so that when they send the patient to me, I can actually opine as to whether it truly is or isn't. And I would say that that's a mixed bag about what comes back.

Q. Dr. Saeed raised the issue potentially of CRPS on her very first examination of Mr. Narsimhan on 7/17/2018. Did you see that?

A. That is correct, and I'm looking for that record. I'm having trouble finding it. But that date is indelled [sic] in my mind, engraved in my mind. So I remember that date. I remember seeing that. But I'm having trouble finding it to read it to remember whether or not she did appropriate documentation on that date.

Q. What does the word -- I saw a word in the records, Doctor, I don't understand. What is dysesthesias, d-y-s-e-s-t-h-e-s-i-a-s?

A. Could you repeat -- spell it again. Spell it more slowly, please.

Q. D-y-s-e-s-t-h-e-s-i-a-s.

A. Can you write it on a paper, and just put it --

MS. HAY: I think it's dysesthesias.

THE WITNESS: Oh, "D." I didn't hear the "D." Okay, I got it now. Linda helped me.

Dysesthesia means an abnormal sensation. Something feels differently than it's supposed to feel.

BY MR. BERMAN:

Q. Is that a potential indication of CRPS sensory criteria?

A. Not a big one unless you consider allodynia dysesthesia, which I don't. Dysesthesia could be feeling like ants are crawling on you, which is also a form of dysesthesia called formication. But it's like, if you touch somebody and it feels differently than what you're touching, or you just have different -- dys means not functioning properly, and esthesia means sensation. So sensations not working right is what dysesthesia is.

Q. Can that be a sensory -- can that relate to the sensory category of CRPS symptoms or signs?

A. Clinically, yes.

Q. What is claudication?

A. Claudication is essentially decreased blood flow to an area.

Q. Is claudication pain and burning pain?

A. No.

Q. No? What are the symptoms of claudication?

A. Feeling of ischemia.

Q. What does that mean?

A. What does that mean? Ischemia is decreased blood flow.

Q. What does decreased blood flow feel like to a patient?

A. Very unpleasant.

Q. Painful?

A. Yes.

Q. So claudication-like symptoms would be painful symptoms, right?

A. Yes.

Q. Very painful, right?

A. Caused by decreased blood flow.

Q. Well, claudication-like symptoms would be symptoms that are severely painful, correct?

A. Claudication is claudication. Claudication is basically too little blood flow to the muscles

during exercise is what claudication is.
Q. Is claudication a diagnosis?
A. Well, it's a sign or it's a symptom.
Q. The words "claudication-like symptom" would be describing the feeling a person has from claudication; wouldn't you agree?
A. I don't really understand the question.
Q. You know what claudication is?
A. Right.
Q. You know what claudication symptoms feel like, right?
A. Yeah, it's usually like a cramping of the muscles because -- okay. There are two kinds of claudication. There's vascular claudication. There's spinal claudication. And basically, you're walking down the street and your legs cramp up because they're not getting enough blood flow or that the spine is not providing enough positive input into the leg that the legs cramp up, and you can't walk anymore. That's what claudication is. So it's essentially a muscular kind of problem, not nerve kind of problem.
Q. But patients don't come to you and say, "Hey, Doctor, I'm feeling claudication today," do they?
A. That's -- I mean, is a patient going to come

to me and tell me they have paroxysmal atrial tachycardia or paroxysmal delancination. I mean, a patient doesn't come to me and tell they have claudication.
Q. Right. Patients comes in and tell you that they're feeling pain or burning pain, and doctors have to describe it in some way, right?
A. Right, okay.
Q. And a doctor may describe burning pain as claudication-like symptoms, right?
A. Are you testifying to that or making it up?
Q. Can you answer my question, Doctor?
A. Well, they wouldn't do that because it's wrong.
Q. I thought you said claudication-like symptoms would be painful. Is that wrong?
A. Yeah, okay. Hitting your hand with a hammer is painful and putting a soldering iron on your hand is painful, but they're not the same. And having muscular pain due to ischemia is very different than having burning nerve pain, and so they're not the same.
Q. So what does the muscular pain due to ischemia feel like?

A. Cramping. It's a severe dull ache.
Q. Severe dull ache, is that what you said?
A. It doesn't even have to be severe. Dull ache.
Q. It can be severe, though?
A. Can be severe.
Q. So claudication-like symptoms could be a severe dull ache, correct?
A. Correct, yeah.
Q. The only reason I'm asking you that is Dr. Farbman on 2/9/17 wrote down "claudication-like symptom." Do you know what he's referring to there?
A. Well, I mean, that could be ischemia caused by diabetic -- not peripheral neuropathy, but by sequelae of diabetes because that's very, very common in diabetes.
Q. Or it could just be he's describing a severe dull ache, right?
A. Well, you have to have a reason to have the dull ache.
Q. Going back to your medical examination. Relative to requirement No. 4, you said requirement No. 4 of the Budapest criteria was not met because there was another explanation for Mr. Narsimhan's

right lower extremity pain, and that was diabetic peripheral neuropathy with pain, correct?
A. Right, which it looks like on this occasion I would have to say that that's not accurate.
Q. What do you mean by that?
A. I mean, I have to withdraw No. 4 not being satisfied.
Q. So previously based on your report, your examination when you said requirement No. 4 was not satisfied, you're withdrawing that, and you're saying it was satisfied as of right now, right?
A. Correct.
Q. Understood.
I'm just looking at your report. I'm just going to wrap up here, just getting some report questions done.
In your report on page 5, your independent medical examination report which is Exhibit B-1, page 5, the sixth paragraph down.
A. Hold on. Okay, page 5.
Q. The sixth paragraph down where it says, "Mr. Narsimhan has diabetes mellitus" -- actually, I'm going to skip that and go down to the next paragraph, which is, "Mr. Narsimhan was not considered to have a

diagnosis of complex regional pain syndrome until three years after the incident." Do you see where you wrote that there?
A. It should have been two.
Q. It should have been two.
In your experience, I mean, in your clinic and in your work as a medicolegal examiner, is there some range of timing when CRPS gets actually diagnosed after a traumatic event?
A. Yes.
Q. What is that range?
A. It's usually within three months that the patient has unrelenting problems and seeks care to the point that they get care unless they don't have insurance. That's the only situation -- I would say that's pretty much the only situation when somebody has active CRPS that they don't start getting treated for CRPS in the first three months unless -- I mean, not in Chicago, okay, but if they were in the boonies somewhere, then it could happen. But like in LA, which is the same as Chicago for all intents and purposes as we're talking here today, if you have CRPS and you're at month three and things are bugging you, you're going to a doctor on a regular basis and

complaining about how bad it is. That's the natural course of CRPS.
Now, there are doctors that have a dull ear toe to that. And, you know, it may be gratuitous for me to be saying that here, but, you know, they still usually will write it down and then ignore it. But what we have here is a guy who's getting a lot of medical care, and he's just not behaving like a CRPS patient would behave saying, "We got to get rid of this. You know, you really got to treat me. I need something done about this." And we're just not seeing that, and that's the reality of the world I live in.
Q. In Mr. Narsimhan's case, within two months after his incident at Lowe's, so on August 2nd, 2016, he's prescribed a medication called Lyrica. Is Lyrica used for nerve pain, to treat nerve pain?
A. Yes.
Q. Can Lyrica be used at times to treat CRPS pain?
A. Yes.
Q. I know that obviously we talked about this. At some point the Lyrica was changed to Gabapentin. But at least you agree with me as of August 2nd, so within that three-month time frame after the incident

at Lowe's, Mr. Narsimhan is being prescribed Lyrica which potentially could be a treatment for CRPS pain, right?
MS. HAY: Objection, asked and answered. You can answer again, Doctor.
THE WITNESS: I'd say I haven't answered it for Lyrica. I answered it for Gabapentin. They're cousins, and either can be used. And neither is FDA approved for that purpose. And I don't think we separated out the hand neuropathic pain at that point from leg neuropathic pain, so I don't really know which he was prescribed for. Are you saying August of 2016?
BY MR. BERMAN:
Q. Yes, Doctor, 8/2/2016, August 2nd.
A. Is that Farbman?
Q. It is, Doctor.
A. Okay. Let me just pull it up.
I'm just looking for that. I have Dr. Saeed's notes in front of me now, which I couldn't find before. I think I have Farbman's notes. I'm having trouble finding Farbman's notes as we're speaking here.
MS. HAY: I don't know if -- they were under

Northwest Neurology, if that helps, Doctor.
THE WITNESS: Yeah, except the Northwest Neurology I'm pulling up right now is only pulling up Dr. Saeed's notes.
MS. HAY: I thought they were all in one bundle, but I think some of them might have been a little out of order.
Doctor, are your Northwest Neurology notes Bates stamped?
THE WITNESS: They're not Bates stamped.
BY MR. BERMAN:
Q. Doctor, for this reason -- at the very beginning of the deposition I asked you to put your file on a disc or in a drive somewhere and get it to defense counsel so they can get it to me. I'm asking you to get all your records, whatever you reviewed in relation to this case, put it all on one drive, and let me take a look at what you got. So I appreciate that. Thank you.
MS. HAY: I don't know if it will help you then, Doctor, but the August 2nd, 2016, note that I have is Bates stamped page 39 out of 58 pages total, if that's helps.
THE WITNESS: It doesn't look like -- I don't

know what happened, but it looks like it's missing. Oh, wait.
BY MR. BERMAN:
Q. Can we move on, Doctor?
A. Well, you want -- yeah, you can. I'm just having computer problems right now, but I think I found it. It looks like I found it. I'm sorry. It's just not easy to find right now. You can move on.
BY MR. BERMAN:
Q. I'm going to share my screen, and show you what's attached as Exhibit B to your deposition. And this is B-3. It's your three-page expert report.
A. Right.
Q. My question for you, Doctor, is this a document you typed or is this something that defense counsel typed and you signed?
A. No, this looks like my typing.
Q. So page 1 of Exhibit B-3 is, No. 1, Qualifications. That's all your qualifications. That's true for any expert report you do no matter what, right?
A. Correct.
Q. All right. So this --
A. No, that's not true. That's true for ones

that I do with regard to complex regional pain syndrome.
Q. So you use this page of qualifications for any report you do for complex regional pain syndrome?
A. Well, actually, I kind of create each individually, but this is the one I created as my qualifications for CRPS.
Q. Is this a cut-and-paste job for qualifications you've used before?
A. I don't believe so, no.
Q. And page 2 is your opinions, and it goes on to page 3, right?
A. Yes.
Q. And you would amend these opinions based upon your testimony today, right?
A. Excuse me?
Q. You would amend your opinions based upon your testimony today, right?
A. Correct.
MS. HAY: I'm sorry. You trailed off, Steve. Sorry.
MR. BERMAN: Judy, what did I say?
(Whereupon, the record was read as follows:

"Q. You would amend your opinions based upon your testimony today, right?
A. Correct.")
BY MR. BERMAN:
Q. Lastly, Doctor, I know we went over your examination. I'm going a little bit further. One thing I wanted to ask you relative to your examination of January 15th, 2021, had you upon examination found one additional sign of CRPS in the vasomotor, sudomotor, or even motor/trophic, the Budapest criteria would have been met, and the diagnosis would have actually been CRPS, correct?
MS. HAY: I'm sorry. Steve, you're just getting distorted. Ms. Court Reporter, did you hear that?
(Whereupon, the record was read as requested.)
MS. HAY: Did you hear and understand that, Doctor?
THE WITNESS: I did, and I answered it twice. Yes.
MR. BERMAN: I'm sorry, Doctor, it's been so long. We're over three hours. I have no further

questions at this time.
THE WITNESS: I thought it was going for four hours.
MR. BERMAN: Do you want me go another hour, Doctor?
MS. HAY: I've got some questions.
THE COURT REPORTER: Could I just take two minutes?
MS. HAY: Sure.
(Whereupon, a short break was taken, after which the following proceedings were had:)
EXAMINATION
BY MS. HAY:
Q. Doctor, the report that you prepared with regard to this matter that outlines your qualifications, as well as your opinions, are those all opinions that you hold to a reasonable degree of medical certainty?
A. They're not all of them, no.
Q. Are the ones that are listed here in that report, are those your -- are those opinions all to a reasonable degree of medical certainty, though?

A. Wait.
MR. BERMAN: Which report?
MS. HAY: His expert report.
THE WITNESS: So I have to break the question -- I'm not trying to be -- I am a little punctilious here. But why don't you ask the first question -- oh, the first one was, were they all my opinions; is that correct?
BY MS. HAY:
Q. Let me restate it, Doctor. In your expert report where you lay out your opinions -- do you have that in front of you?
A. No, but I can get it.
MR. BERMAN: Exhibit B-3.
THE WITNESS: You want to just put it on the screen. It will be easier than me finding it and save us some time.
MR. BERMAN: I can do it quickly.
MS. HAY: If you can do it quickly because I'm on my iPad.
THE WITNESS: Okay, there it is. Yes.
BY MS. HAY:
Q. Doctor, are these all of your opinions to a reasonable degree of medical certainty?

A. They are not.
Q. Can you tell me are there -- what's the reason for that?
A. The reason for that is that there are different -- there are additional records that have been provided to me since then, and they have allowed me to form other opinions.
Q. Doctor, can you just be a little more clear for me with regard to which opinions are different?
A. Well, they're not different. You just said they're additional.
Q. Which are the -- can you tell me what additional opinions you have?
A. Yes. I have an opinion that there's a marked discrepancy between the way I conducted the exam on 1/15/21 than the way Dr. Patel documented the way that Mr. Narsimhan said I did it, and we could go into greater detail. But what I can tell you is that there was an intervening exam performed a month later which was a month before Dr. Patel's exam, and in that exam there was no mention of an exacerbation occurring as a result of -- I don't know what words to use -- hold on. I'll get you the exact words so you have it. In which Mr. Buvanendran indicated that his right --

Q. Excuse me. You mean Mr. Narsimhan?
A. Yes, sorry. I misspoke.
Mr. Narsimhan claims that his right leg was handled in a rough manner in which a flare of his CRPS -- which prompted a flare of his CRPS. Now, very interesting that the same gentleman who reported that to Dr. Patel on -- in March of 2021, did not report that at an intervening examination in any way that he had a flare or that he had his limb handled in a rough manner. And what I can say is, number one, in that regard as somebody who's an expert in CRPS, I'm exquisitely sensitive to the fact that CRPS patients can have bad reactions to what is done. And so I am extra careful in my medical practice in avoiding anything that could traumatize a patient. Now, that's in my medical practice.
In my medicolegal practice, especially when I am evaluating on behalf of defense, I am extraordinarily cognizant of that, and even more careful than I am in my clinical practice. And what I can tell you based on what my written documentation that was done before this accusation is that I indicated on every occasion that I deferred a part of an examination because of his complaints of pain, and

it's really incredulous to me with Mr. Berman present who would have stopped me if I was doing anything painful to his client, with my special care to do that, with him not complaining about it a month later that he would then at a plaintiff's expert examination then come up with this accusation is patently not true.
Q. Doctor, as far as the record that you relied upon where that suggestion or outright statement was made, was that to your understanding made in an accounting when he went to Rush Pain Clinic on March 2nd, 2021, and made that complaint to Dr. Patel, a fellow in Dr. Buvanendran's office?
A. Yes.
Q. Was there any indication -- so your independent medical exam was on January 15th of 2021, correct?
A. Correct.
Q. And this complaint then that Mr. Narsimhan made about your rough handling of him was made about two months later, fair?
A. Correct.
Q. And was there any indication that you saw in any of the records that you were provided surrounding

Dr. Patel/Buvanendran's evaluation on March 2nd that Mr. Narsimhan had contacted any of those doctors at Rush prior to March 2nd but after your examination?

A. No.

Q. Within that time period, Doctor -- well, one other question about that. Was it your understanding as well that Mr. Narsimhan on March 2nd for the first time told Dr. Patel and/or Dr. Buvanendran that as a result of your rough handling he had a "flare" of his condition in his lower extremity?

A. That's what I just read.

Q. And was it your understanding that at that evaluation as well he now complained that he had had some more significant complaints now to his left lower extremity?

A. Yes.

Q. And that complaint -- I'm looking at the wording in that report, and it says, "Now he has left leg burning pain in dorsum of foot, slow nail growth, no hair growth. He continues to work." And that's in the third paragraph under history and physical?

A. Yes.

Q. Within that time period, was it your understanding also, Doctor, that in February of 2021

it in his deposition should it have occurred, should it have been reported to him as the expert.

Q. With regard to Dr. Joshi, is it your understanding that Dr. Joshi -- well, strike that.

Do you believe that your qualifications with regard to this particular case exceed those of Dr. Joshi as it may apply to either your treatment of CRPS patients or your experience, education, and training in the area of diabetes?

A. Well, first, I mean, I want to say in fairness to Dr. Joshi, I believe he's a qualified physician. He's a qualified pain physician. So I don't want to underrate him in any regard, and I always have respect for board-certified physicians. He's a board-certified pain physician. But there are two things that you bring up in your question that really need to be addressed. And the first one is, do I have more qualifications in CRPS, and I think Dr. Joshi would not dispute that I do. I mean, it's what I do for a living. It's 80 percent of my new patients, and I've been doing it for 25 years. And I believe I have more qualifications in CRPS than he does without trying to diminish him in any other way.

With regard to the second question that you

that Mr. Narsimhan saw the plaintiff's retained expert for an independent medical exam, Dr. Joshi?

A. Wait. On what day?

Q. In February of 2021, a month after your examination.

A. Yes.

Q. And I believe the date of that was February 19th, 2021. Does that sound about right to you?

A. Yes.

Q. Was there anything you recall reading in either the report of Dr. Joshi's independent medical exam or Dr. Joshi's deposition where he indicated that Mr. Narsimhan complained to you that you were rough in your treatment of him in your exam?

A. No.

Q. Was there any indication that you recall reviewing in either Dr. Joshi's examination, report, or in his deposition that Mr. Narsimhan had a flare after your evaluation on January 15th?

A. No. And just to point out, Ms. Hay, to be fair to all of us, Dr. Joshi did not have his deposition taken until April, so that what occurred in February should have -- he should have commented upon

asked, I am a board-certified internist having taken care of medical patients for a significant portion of my career, having completed an internal medicine residency, and as a result I have experience in dealing with obese, diabetic patients.

Q. Doctor, with regard to -- well, strike that.

As to the Budapest criteria, Doctor, do you feel you are well qualified to apply the Budapest criteria?

A. Yes.

Q. Is it important to you, Doctor, in applying the Budapest criteria that there are precise measurements and assessments that are done with regard to the various categories that need to be assessed?

A. Yes. I wanted to point out one other thing that I wasn't given the opportunity to say, which is, in Dr. Patel's note that was signed by Dr. Buvanendran, we also, once again, have the identical physical examination that has gone through the record from visit to visit to visit. So I think it is very safe to say that given that that examination was pasted from other examinations that we really do not know what the examination was on that day.

Q. Doctor, on page 27 of Dr. Buvanendran's deposition, he was asked this question and answer, and I'm going to read it for you and ask if this is consistent with your comments with regard to the records of Dr. Buvanendran through some of his visits. And for the record, I'm reading on page -- starting on page 26 and continuing on to page 27. The question is, "And, in fact, the entire examination section that you've written, down to the punctuation is exactly the same as the prior visit. Is it unusual that your examination of the patient three months later is exactly the same?" Answer: "No, it's not. You asked" -- and then there's some objections. Dr. Buvanendran continues in answer: "You know, when I see a patient and make a diagnosis, we don't -- it's part of an electronic medical record. The records are carried over from the previous time. But the fact is I do examine the patients every time, and if there are similar findings, I don't go correct everything. It's just this auto populates the facts. So it is very similar whether it's 2.2 or 2.1. It's not a huge deal to me. I'm treating patient -- a patient here. I'm not treating numbers or doing legal stuff. So I'm trying to treat the patient, and you want to be able

to provide appropriate medical care once you know what the diagnosis is. You don't need to be documenting every time you see a patient." And I don't think the last sentence really applies.

Does that support, Doctor, your comments with regard to some of the credibility issues about Dr. Buvanendran's findings in his notes?

A. Well, before I answer that, I just want to tell you, Ms. Hay, that I had one of my trainees copy a note from one visit to the next, and I warned him that if he did it again he wouldn't be working with me. That I feel extremely strongly, and it is -- it's not just me. It is the standard of care that what you do on a specific day is what happened on a specific day. And to copy something from another day is -- I mean, sometimes they copy from other doctors, and essentially that's plagiarism. But here he copied from himself, and whether he cares about the numbers or doesn't care about the numbers, he shouldn't be documenting numbers from another occasion because that's not what happened on that day, and it's misleading. And it is below the standard of care, very clearly, Ms. Hay, it is below the standard of care to copy a note from one day and put it in another

day.

Now, there a lot of things that don't change that are self-populated like all the medications the patient is taking, what the prior history is. But the exam on that day is something that happens on that day, and there is no freedom, absolutely no freedom to copy the exam from a different day into that day. And I don't think I can be any more clear on that.

Q. Doctor, is it your opinion to a reasonable degree of medical certainty that Mr. Narsimhan does not fit the diagnosis for CRPS?

A. Based on my examination, yes.

Q. You were asked some questions with regard to Dr. Matiwala's assessment of Mr. Narsimhan's diabetic condition, and I know you talked a little bit about his diabetic condition prior to the event at Lowe's. Was it your understanding that in accord with Dr. Matiwala's comment that an AIC over 7 or above would not indicate a good control of a diabetic; that there were AIC numbers that Dr. Matiwala recorded after the Lowe's event that were indeed 7 and above?

A. It's not AIC. It's A1C.

Q. I'm sorry. A1C.

A. Sorry. I'm not being fussy.

Q. That's okay. Thank you.

A. I am not recalling others. I don't want to say one way or the other where I saw them or not, but I don't want to swear to the fact that I saw other numbers over 7 in Dr. Matiwala's notes. But I certainly wouldn't rule that out. I have to swear that I can't remember.

Q. That's okay. If you don't remember, Doctor, that's fine.

With Dr. Matiwala's records, whatever the A1C numbers are in his records after the event you would agree would be numbers we could rely upon, fair?

A. Exactly and fully fair.

Q. Doctor, we were recently provided with, and I provided you with some photographs that were taken of apparently Mr. Narsimhan's feet. Do you recall getting those photographs?

A. Yes. I can pull them up because I do know exactly where those are.

Okay, I got them.

Q. And, Doctor, it's our understanding that these photographs -- I'm not sure if you had the actual dates, but on representation by Mr. Berman, and he can correct me if I'm wrong, these photographs were

taken by either Mr. Narsimhan or his wife and were taken I believe the first -- it might be tough to pinpoint the actual dates. But the first two were taken in I believe about August 2019 and the remainder in the later half of 2020.

MR. BERMAN: For the record, I did provide counsel with the exact dates the pictures were taken, if you recall.

MS. HAY: That's correct, you did, Counsel. But I think that's about the range that we were talking about generally speaking.

BY MS. HAY:

Q. With regard to those photos, Doctor, does anything in these photos change your opinion that Mr. Narsimhan does not have CRPS?

A. There is only one out of all those photographs, which is the next-to-last photograph that there's a comparison where there appears to be any kind of difference, and that difference is predominantly scaling that we could explain a variety of ways, including not washing your foot. And so all the others -- I could comment on each one individually why they don't mean anything to me. And on this fifth one, we would use basically requirement four if it

were showing up on that day to say that the only thing that looks different is the scaling, and that that scaling -- you know, the color -- likely looking at the other pictures, his one foot has more exposure to the sun than the other one. That's where I would explain the pigmenting in the first picture between the two feet. CRPS pain looks like -- the sign looks like a sun exposure sign. And in this one, which is the next-to-the one, that's not usually what you see as a CRPS skin change anyway, but if you want to call it that. We don't know what circumstances happened. For all we know, that's wet talcum powder on the foot. I don't know. I'm not there. I can't smell it; I can't feel it; and I can't say it means anything anyway.

Q. With regard to CRPS, Doctor, I know you indicated that patients can have some good days and some bad days, right?

A. Correct.

Q. We know, though, that Mr. Narsimhan specifically described what he told Dr. Patel apparently was a flare after your IME, fair?

A. Fair.

Q. Was there any indication in any of the

records or anything that you've seen that would indicate that Mr. Narsimhan during the course of some flare took any specific photos of his feet during the time of that flare?

A. No.

Q. Is there any indication through any of the other -- of the numerous medical providers that he's seen that would suggest to you that they took any photographs of his feet to confirm how his feet may appear differently by way of a photograph?

A. Well, the answer to the question is there are none. And not to be gratuitous here, but the more important thing is there's no complaints as documented telephonic notes or physician visits that demonstrate that any of that ever occurred.

Q. Doctor, other than the additional opinion that you talked about in light of Dr. Patel's report and we've talked about the photograph, have we essentially covered the bulk of your core opinions in this case with regard to Mr. Narsimhan?

A. Yes. I would just, Ms. Hay, acknowledge that based on the review that Mr. Berman pointed out that the likelihood of diabetic peripheral neuropathy is somewhat decreased, but my most important opinion in

this case is that there is not adequate documentation between 2016 and 2018 of CRPS. And hypothetically, even if we accepted a diagnosis of CRPS on 1/15/21, there is no way you could make a causal link between what happened in 2016 and what happened in 2018. Because, as I pointed out to Mr. Berman, if there was active CRPS between 2016 and 2018, the person active in the medical system would have complained about what he complained about, and then the Wheaton Chiropractic records where he himself filled out a form where he indicated hand pain but didn't indicate foot pain or leg pain is more evidence that nothing was bothering -- that the foot was not a CRPS kind of foot or leg or not CRPS issues at that time and during the succeeding three months where there was never any mention of the foot or the leg as sufficient information to indicate that between 2016 and 2018 that there was no CRPS whether or not we hypothetically accept that there was a diagnosis.

Q. But your opinion as you sit here today is that he does not have CRPS based upon all of the information that you've reviewed, your examination, your report, as well as your education, training, and experience; is that correct?

A. Based on my examination, that is true.
Q. And I take it, Doctor, given that you've talked about pretty extensively the nature of your practice with many CRPS patients that you diagnose and do treat that you're familiar with the chronology overall of how CRPS would proceed, and during that time frame, it didn't proceed according to that typical chronology; would that be fair?
A. Yeah, I think that just repeated what I said.
MS. HAY: Thanks, Doctor. That's all I have.
THE WITNESS: Wait. I have one other thing that I don't know whether it was put in there or not. But there clearly is a standard of care for a CRPS patient, and that is comprehensive interdisciplinary functional rehabilitation. That's a whole bunch of long words, and I could -- if Mr. Berman wishes me, I could go into more detail about what that is. But the bottom line is, Dr. Buvanendran, I expressed a very good opinion of him and said he's well respected. At the same time, as somebody who has the knowledge of CRPS, he should know that that is the gold standard for care. Dr. Joshi claims to be an expert in CRPS, and neither Dr. Joshi nor Dr. Buvanendran ever recommended the gold standard for care.

I mean, we start talking about possibly doing dorsal root ganglion stimulation, which is in Michael Stanton-Hicks -- I think I mentioned him, Mr. Berman, from the article. And in it he said failure to progress with conservative therapy -- which is the comprehensive program that I was talking about called FRP for functional rehabilitation program. Failure to progress with that is an indication to move toward interventional therapy. But until you try FRP, you cannot say the patient is appropriately being treated, and we don't know -- again, hypothetically, if we accept their diagnoses of CRPS, then he long ago should have been involved in functional rehabilitation to get him to a state where he wouldn't be complaining of what he's complaining about. He wouldn't complain that he was manhandled when he wasn't.
So it's very important that this was left out by people who claimed to know about CRPS. They didn't treat him like a CRPS patient. And the question that I would ask is, if they truly believe he has CRPS, why wouldn't they treat him like a CRPS patient?
BY MS. HAY:
Q. Would it be fair to say then, Doctor, that despite other treaters' diagnoses of CRPS their actions with regard to treatment recommendations were inconsistent with that finding?

A. Yes.
Q. And are those your opinions, Doctor, to a reasonable degree of medical certainty as well?
A. Yes.
MS. HAY: That's all I have. Thank you.
FURTHER EXAMINATION
BY MR. BERMAN:
Q. I just have a couple follow-up just real quickly.
A. Thank you, Mr. Berman.
Q. During your examination of Mr. Narsimhan when you were actually physically examining him, doing your physical examination, your hands were shaking, Doctor. Can you tell us why that is?
A. Yes. I have a tremor from hypoglycemia, and I didn't have lunch that day. Normally, just so you know, when I do surgery and I don't have breakfast, I take a medication that makes that tremor go away.
Q. That's fine.
And two other things. After your examination, Doctor, of Mr. Narsimhan, did you watch him walk down the hall after he left the room where you performed the examination?

A. I did.
Q. You watched him walk down the hall?
A. I believe I did, yes.
Q. You're saying you opened the door, you looked out the door, and was watching him go down the hallway? I was there, Doctor.
A. Right. And I'm trying to remember because -- I did two very similar situations, and I'm just trying to remember if this was the one or the other one was the one. But I think it may have been the other one. And so, I mean, on one of them, I watched the guy walk down the hall, and there was no limp whatsoever. I can't swear to it that this was the one of those two, because they were both in reasonable temporal proximity to each other that I did very similar kind of exams.
Q. I can tell you this, because we looked back after as we're walking down the hall, we didn't see you poking your head out the door. So fair to say that you can't recall observing Mr. Narsimhan walk from the door of the hotel room where the examination was performed down to the elevator; is that fair?
A. I thought I did, but I don't want to swear to

it.

Q. Did you watch Mr. Narsimhan go from the hotel into the car?

A. No.

Q. So as far as you can recall, your only interaction and observations of Mr. Narsimhan were within the hotel room where the medical examination was performed, correct?

A. Correct.

MR. BERMAN: That's all the question I have.

MS. HAY: Thanks, Doctor. I don't have anything further. We'll reserve signature.

(Witness excused at 6:57 p.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KRISHNA NARSIMHAN,)
)
Plaintiff,)
)
-vs-) Case No. 1:19-cv-01255
)
LOWE'S HOME CENTERS, LLC,)
)
Defendant.)

I, JOSHUA P. PRAGER, M.D., being first duly sworn, on oath, say that I am the deponent in the aforesaid deposition, that I have read the foregoing transcript of my deposition taken 21st day of June, 2021, consisting of Pages 1 through 160 inclusive, taken at the aforesaid time and place and that the foregoing is a true and correct transcript of my testimony so given.

_____ Corrections have been submitted
_____ No corrections have been submitted

_____
JOSHUA P. PRAGER, M.D., Deponent

SUBSCRIBED AND SWORN TO
before me this _____ day
of _____ A.D., 2021.

_____
Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

I, Judith T. Lepore, Certified Shorthand Reporter in the State of Illinois, do hereby certify that on the 21st day of June, 2021, the deposition of the witness, JOSHUA P. PRAGER, M.D., called by the Plaintiff, was taken before me via videoconference, reported stenographically and was thereafter reduced to typewriting through computer-aided transcription.

The said witness, JOSHUA P. PRAGER, M.D., was first duly sworn to tell the truth, the whole truth, and nothing but the truth, and was then examined upon oral interrogatories.

I further certify that the foregoing is a true, accurate and complete record of the questions asked of and answers made by the said witness, at the time and place hereinabove referred to.

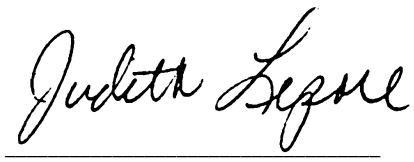
The signature of the witness was not waived by agreement.

Pursuant to Rule 30(e) of the Federal Rules of Civil Procedure for the United States District Courts, if deponent fails to read and sign this deposition transcript within 30 days or make other

arrangements for reading and signing thereof, this deposition transcript may be used as fully as though signed, and the instant certificate will then evidence such failure to read and sign this deposition transcript as the reason for signature being waived.

The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.

IN TESTIMONY WHEREOF: I have hereunto set my verified digital signature this 8th day of July, 2021.



_____
Judith T. Lepore, CSR

License No. 084-004040

McCorkle Litigation Services, Inc.
200 N. Lasalle Street, Suite 770
Chicago, Illinois 60601-1014

July 8, 2021
LINDA HAY, ESQ.
HEPLER BROOM LLC
30 North LaSalle Street
Suite 2900
Chicago, Illinois 60602
IN RE: Krishna Narsimhan v Lowe's Home Centers
COURT NUMBER: 1:19-cv-01255
DATE TAKEN: June 21, 2021
DEPONENT: Joshua P. Prager, M.D.

Dear Ms. Hay:

Enclosed is the deposition transcript for the aforementioned deponent in the above-entitled cause. Also enclosed are additional signature pages, if applicable, and errata sheets. Per your agreement to secure signature, please submit the transcript to the deponent for review and signature. All changes or corrections must be made on the errata sheets, not on the transcript itself. All errata sheets should be signed and all signature pages need to be signed and notarized.
After the deponent has completed the above, please return all signature pages and errata sheets to me at the above address, and I will handle distribution to the respective parties. If you have any questions, please call me at the phone number below.

Sincerely,
Cindy Alicea
Signature Department

Judith Lepore
Court Reporter
(312) 263-0052

cc: S. Berman

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